HIV/STD

PROGRAM EVALUATION

UNDERSTANDING EVALUATION TECHNIQUES:

The Building Blocks of Evaluation

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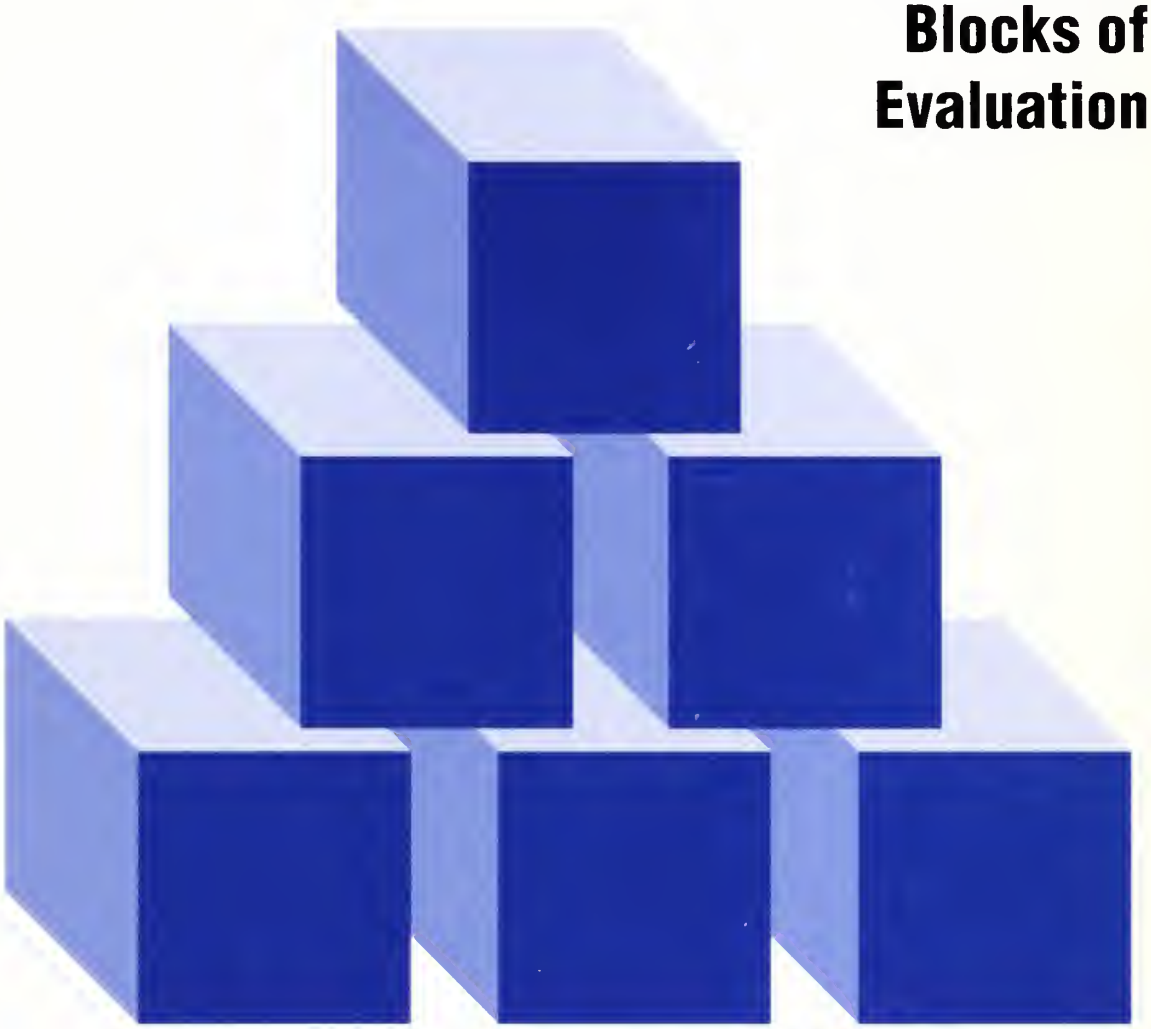

NCLR CENTER FOR HEALTH PROMOTION

NATIONAL COUNCIL OF LA RAZA

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THE NATIONAL COUNCIL OF LA RAZA
CENTER FOR HEALTH PROMOTION

The NCLR Center for Health Promotion provides technical assistance to NCLR affiliates and other national, regional, and local entities which share a commitment to health-related education and disease prevention in the Hispanic community. The NCLR Center for Health Promotion houses the following initiatives:

- The NCLR AIDS Center, established in 1988 through a grant from the Centers for Disease Control and Prevention, carries out interrelated activities built around the concept of an interactive HIV/AIDS network: information sharing, development of guides and manuals, development of program models, training, and capacity-building technical assistance.

- The Hispanic Health Liaison Project, established in the fall of 1991 through a grant from the Office of Minority Health, is designed to provide information, assistance, and support to Hispanic community-based organizations committed to increasing Hispanic involvement in preventive health efforts, and serve as a bridge between community-based organization and mainstream agencies, public and private. A major product of the project will be a comprehensive report on Hispanic health status designed to increase awareness and understanding of Hispanic health needs among policy makers, mainstream organizations, the media, the Hispanic community, and the general public.

- Special health initiatives such as an analysis of Hispanic health insurance coverage and seminars and conference workshops on substance abuse, HIV/AIDS, and other health issues.

THE NATIONAL COUNCIL OF LA RAZA (NCLR)

The National Council of La Raza (NCLR), the largest constituency-based national Hispanic organization, exists to improve life opportunities for the more than 22 million Americans of Hispanic descent. In addition to its Washington, D.C. headquarters, NCLR maintains field offices in Los Angeles, California; Phoenix, Arizona; McAllen, Texas; and Chicago, Illinois. NCLR has four missions: applied research, policy analysis, and advocacy on behalf of the entire Hispanic community; capacity-building assistance to support and strengthen Hispanic community-based organizations; public information activities designed to provide accurate information and positive images of Hispanics; and special innovative, catalytic, and international projects. NCLR acts as an umbrella for 160 affiliates — Hispanic community-based organizations which together serve 37 states, Puerto Rico, and the District of Columbia, and reach more than two million Hispanics annually.

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UNDERSTANDING EVALUATION TECHNIQUES:
The Building Blocks of Evaluation

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I. INTRODUCTION

A. *About this Manual*

This guide, *Understanding Evaluation Techniques: The Building Blocks of Evaluation,* is part of an ongoing effort by the NCLR AIDS Center to assist Hispanic community-based organizations evaluate their HIV/STD education and prevention programs. It supplements the NCLR AIDS Center's earlier manual, *Evaluating AIDS/STD Education and Prevention Programs: An Introduction.* The first manual was developed to help project staff take the first steps in planning and carrying out necessary and practical types of documentation and evaluation of HIV/STD prevention programs. This manual expands on that effort by focusing on basic, cost-effective program evaluation techniques which can provide valuable information about the effectiveness of each step of an HIV/STD prevention program. This manual also provides general guidance on determining what kinds of evaluation results are meaningful and obtainable in a community setting and strategies that are appropriate and sensitive to the cross-cultural populations served by community-based organizations, especially Hispanic and other minority-oriented agencies.

The intended users of this guide are professionals involved in HIV/STD issues or in delivering HIV/STD education and prevention services to Hispanic and other minority groups, managerial and field staff of AIDS programs in Hispanic community-based organizations, their public- and private-sector funders, community and migrant health centers, and other AIDS and human services providers.

The evaluation techniques described in this manual include: use of experts, focus groups, community interviews, demonstration sessions, observers, informal surveys, and games. These techniques can be used individually to achieve a successful evaluation. However, as community-based organizations become comfortable using one or two techniques, they are encouraged to build in additional ones for a more comprehensive evaluation plan. For community-based organizations with little or no evaluation experience, this manual provides a set of concepts and strategies necessary for beginning program evaluation. For organizations with more evaluation experience, this guide should provide insight into the strengths and weaknesses of current evaluation practices and ideas for broader approaches.

The techniques described are ones which NCLR has found effective and do not include all possible methods for evaluation. Although the information and terminology is in accordance with the Centers for Disease Control and Prevention (CDC) guidelines, this manual reflects NCLR's preferred methods and should *not* be viewed as the only model for evaluation.

Community-based organizations are urged to begin to develop comprehensive evaluation plans for their HIV/STD programs. Once organizations gain practice in using the evaluation techniques described in this manual, they will discover that program evaluation is feasible, manageable, and beneficial.

B. The Need for Evaluation

The HIV/AIDS epidemic, now in its second decade, continues to disproportionately affect the Hispanic community. In the absence of a proven cure for AIDS, the need to continue carrying out HIV/STD education and prevention activities, outreach to groups engaging in high-risk behaviors, and other AIDS-related services is clear. What remains unclear are what types of programs and interventions* are effective in reducing the spread of HIV/STDs. The implementation of new health education and risk reduction (HERR) activities and expansion of existing ones will increasingly be contingent on the ability of organizations to evaluate the benefits of their efforts. If organizations do not evaluate their programs, there is no way of knowing whether interventions are effectively serving the needs of clients, or where improvements should be made. To date, little data on the effectiveness of primary prevention programs has been generated.

Ongoing program evaluation can assist in identifying effective strategies or interventions to reduce the incidence of HIV/STD disease. Evaluation, through such approaches as focus groups and informal surveys, reveals what benefits to the client, if any, result from an intervention. It provides information for the program operator to modify approaches which appear ineffective and incorporate interventions which are better targeted to the intended groups. When regularly done, evaluation can provide valuable data on changing community and program needs. Informal surveys collected from a group of high school students can indicate a greater need for "AIDS 102" than for basic "AIDS 101" education sessions. It can identify important issues or populations not being addressed by a program, staff and/or client concerns that program directors may not have been aware of, and other obstacles. The actions taken as a result of carrying out program evaluation can enhance the quality of an HIV/STD program for program staff and the clients of the organization.

Hispanic community-based organizations, Hispanic-controlled institutions committed to the socioeconomic and health advancement of Hispanics, play a critical role in raising the awareness of policy makers about the need for HIV/STD prevention activities. The Hispanic community, expected to become the largest minority population in the United States by the turn of the century, faces many problems which are not well documented, and therefore not

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* **Intervention**, a term used frequently throughout this manual, refers to any planned activity designed to produce intended changes in a target population. Some examples are HIV/STD education workshops, home-based HIV/STD "101" sessions, street level outreach, etc.

well understood. AIDS is a major problem in the Hispanic community, and one which is interrelated with many other issues facing Hispanics, such as high poverty and low educational attainment. One way community-based organizations can educate policy makers and other organizations about the importance and benefits of providing community-focused, culturally appropriate HIV/STD programs is through program evaluation. Because community-based organizations have direct contact with individuals that practice behaviors placing them at risk of HIV/STDs and who would not be reached otherwise with AIDS education efforts, these organizations possess invaluable information about risk behaviors, trends, and the types of HIV/STD interventions most needed in the community. Community-based organizations are in an ideal position to educate policy makers and government officials about the importance and need for community-based interventions. However, policy makers want information which reflects systematic documentation and assessment of community-based efforts.

Funders of community-based organizations are interested in evaluation because this provides assurance that their funds are being spent on effective activities. It is also assuring to know that funds are going to organizations which share common goals and care about the quality their work. A carefully thought out and clearly written evaluation plan increases the likelihood that a project proposal will satisfy a major funding criteria.

C. The Growing Problem of AIDS and Other STDs in the Hispanic Community

The prevalence of STDs among minority groups continues to be a major concern. Some of the most threatening STDs include HIV/AIDS, gonorrhea, syphilis, chlamydia, and pelvic inflammatory disease. Because the same sexual behaviors that place individuals at risk of HIV/AIDS can also place one at risk of other STDs, AIDS education and outreach activities should include education on non-HIV STDs as well.

HIV/AIDS is by far the deadliest sexually transmitted disease. AIDS cases reported in the latter part of the decade have shown that this disease can strike any human being, regardless of age, gender, sexual orientation, or geographic location. A disease that a decade ago was viewed as affecting primarily homosexual White men is now a threat to all population segments, and is affecting minority groups the hardest.

The disproportionate effect of AIDS on Hispanics is evident. Comprising about 9% of the U.S. population, Hispanics represent 16% of total AIDS cases as of June 1992. Hispanic women are less than 10% of the U.S. female population, but make up 20% of total female AIDS cases. HIV disease in pregnant mothers often leads to infection among Hispanic children, who represent 25% of all pediatric AIDS cases. Nor have adolescents been spared; Hispanic adolescents, accounting for 12% of 13-19 year-olds in the U.S. comprise 19% of reported AIDS cases among teenagers.[1] Many more teenagers are possibly

HIV-infected but unaware of it. Because the virus can remain asymptomatic for many years, the magnitude of HIV transmission among today's teenagers will not be fully realized for years to come.

The threat posed by other sexually transmitted diseases must not be overlooked in HERR activities. Not only are transmission modes similar; STD-infected persons are also highly susceptible to HIV/AIDS. The lesions and open sores often caused by STDs allow easy entry of HIV into the bloodstream. The media attention given to HIV/AIDS has overshadowed the threat of, and the interrelationship between AIDS and other STDs. Yet STD rates among minorities remain high compared to rates among Whites. For instance, the 1990 gonorrhea rate for Hispanics was 127.4 per 100,000 compared to 45.8 per 100,000 among Whites. Among Blacks, the rate was 39 times higher, 1,792.1 per 100,000. Primary and secondary syphilis (PSS) has reached epidemic levels. The total PSS rate for 1990 was 20.4 per 100,000, the highest rate in 40 years. Syphilis rates among Hispanics are seven times as high as among Whites (16.8 per 100,000 versus 2.4 per 100,000 in 1990). Among adolescents and young adults, gonorrhea rates are extremely high. The 1990 gonorrhea rate for 15-19 year-olds was 1,060.6 per 100,000; among 20-24 year-olds, the rate was 1,089.9, compared to 525.2 for 25-29 year-olds.[2] Teenagers and young adults, particularly minority women, suffer from other STDs as well, including chlamydia, herpes simplex virus, and human papillomavirus.

Clearly, STD education and prevention messages must be integrated with HIV prevention messages. Although HIV is currently fatal, the risk of acquiring other STDs is much greater than acquiring HIV. Also, many of the same strategies used to prevent the transmission of other STDs are effective in decreasing the risk of HIV infection.

Additional STD information can be obtained by contacting the National STD Hotline at 1-800-227-8922. Other informational sources are the CDC's *Division of STD/HIV Prevention 1991 Annual Report* and the *STD Surveillance 1991* report. These can be obtained by contacting CDC's Surveillance and Information Systems Branch at (404) 639-0511. You may also contact the NCLR AIDS Center to receive a copy of *Adolescents and HIV/STD*, one of several fact sheets developed and updated annually by the NCLR Center for Health Promotion.

D. The Importance of Program Evaluation

Many Hispanic community-based organizations are providing HIV/STD-related services essential to slowing the spread of these diseases. HIV/STD prevention and education sessions, community outreach campaigns, case management, HIV and other STD

counseling and testing, support group services, and street outreach are some of the major activities community-based organizations are undertaking to reduce the incidence of new HIV/STD cases. As these organizations continue to broaden the scope of HIV/STD programs and gain recognition as critical players in the AIDS solution, program evaluation will increase in importance. Three reasons in particular demand that community-based organizations pay greater attention to program evaluation:

- **Evaluation is necessary to assess the progress and effectiveness of HIV/STD-related activities.** It helps to ensure that promising approaches be continued, strengthened, documented, and disseminated, and ineffective approaches be changed. Evaluation is especially important for new projects and models. A good assessment indicates the extent to which activities originally stated in the project work plan were carried out. If some activities changed or if target populations are different, ongoing evaluation can reveal and substantiate the reasons for these changes or the need for a different approach.

- **Systematic evaluation benefits the overall operation of a program.** Evaluation encourages staff to think realistically about the activities required in a project, and whether these are in fact achievable in the timetable specified. It mandates short- and long-term planning, thereby promoting *proactive* versus *reactive* approaches to program development.

- **A clearly-defined evaluation plan can make the difference between a project proposal's approval or rejection.** As more community-based organizations seek first-time funding for AIDS- and other STD-related projects or refunding for existing projects, writing clear evaluation plans for proposed objectives and demonstrating the capacity to carry out such plans will be critical. Only through analyzing the program evaluation plan can funders understand how funds are being spent and the benefits of funding one community group's education and prevention program versus another.

COMMUNITY-BASED ORGANIZATIONS NEED TO EVALUATE HIV/STD PROGRAMS

- To monitor the progress and effectiveness of project activities, make necessary changes or revisions, and contribute to the "state of the art" of HIV/STD prevention efforts.

- To benefit the overall operation of a program by encouraging proactive, long- and short-term planning of activities and minimizing reactive approaches.

- To provide project funders evidence of how funds are being spent and thus demonstrate the benefits of community-based HIV/STD programs.

Many HIV/STD programs of community-based organizations are still relatively new, therefore designing and implementing, or enhancing an evaluation plan should not be as cumbersome as developing one for a long-established program. However, key to a successful evaluation is program-wide commitment to the evaluation process. This entails understanding program goals and objectives; understanding the needs, trends, and risks of the target population; developing appropriate forms and/or surveys to obtain information; training staff on basic community-oriented evaluation techniques such as focus groups and community interviews; and documenting all findings. Corporations place a high priority on these approaches when developing and/or assessing new products or marketing plans, and community-based organizations must begin to do the same.

E. Barriers to Effective Evaluation Encountered by Community-Based Organizations

Community-based organizations face barriers in conducting program evaluation for several reasons. These organizations exist to provide assistance to individuals in need, many of whom would not go to traditional settings for assistance (e.g., runaway youth, drug addicts, or undocumented immigrants). Evaluating knowledge and behavior changes among these groups is often challenging due to the difficulty in maintaining regular contact with them. Because community-based organizations are often the first and primary source of any type of health-related assistance for many Hispanics, heavy emphasis is placed on such services as client education, counseling, outreach, information dissemination, and client referrals. These organizations, which often have limited staff to do follow-up on clients, seldom see the product of their efforts. This makes it very difficult for community-based organizations to measure behavior change directly, and may even discourage organizations from conducting any evaluation at all. Also, community-based organizations often feel under considerable pressure to provide the community they serve with the most comprehensive level of services in spite of limited funds. Due to the reactive nature of community-based organizations' work and emphasis on service provision, evaluation planning has received limited attention. In addition, community-based organizations many times lack the financial resources and staff needed to carry out effective evaluation.

In spite of all that has been written on the subject of evaluation, little of the available material is useful to community-based organizations. Much of the evaluation literature focuses on costly research methods designed to show statistical changes in health outcomes resulting from intervention programs. Moreover, the available data on evaluation are often complex. The use of evaluation terminology is inconsistent, and varies from one report to another. The wide diversity of HIV/STD-related projects obviously complicates the task of designing primary prevention evaluation manuals. Nevertheless, increased efforts must be directed at designing technical assistance manuals appropriate for use with and by staff of community-based organizations. The National Council of La Raza (NCLR) AIDS Center is committed to assisting with this process.

F. Organization of Manual

This guide contains several sections:

Section I provides a general introduction to the manual.

Section II examines the importance of project goals and objectives in program evaluation; objectives are defined in some detail.

Section III discusses the importance of monitoring and assessing all phases of a prevention project or activity. This involves evaluating the design, implementation, and end-of-project results.

Section IV describes different methods for evaluating HIV/STD education and prevention efforts. These include needs assessments, expert reviews, community input, post-session assessments, pre- and post-tests, informal surveys, games, case studies, role plays, key-person interviews, and other methods.

Section V illustrates how various techniques can be applied at any stage of a project in order to assess the many areas that comprise an effective, well-run program. Three HIV/STD education and prevention programs are used as examples: media and community outreach campaigns, informal or street outreach interventions, and HIV counseling and testing programs.

Section VI is the conclusion of the manual.

II. THE IMPORTANCE OF PROGRAM GOALS AND OBJECTIVES IN DEVELOPING AN EVALUATION PLAN

Program evaluation cannot occur without clearly defined goals and objectives. Before a project intervention is designed and implemented, the program goals and objectives must be clearly identified and stated in writing. Not only are they a significant part of the project proposal to funders, but these goals and objectives also serve as a road map for project activities and as a standard for measuring success. The objectives, especially, provide the basis for evaluation; they specify what the program is supposed to accomplish.

A. Goals

A **goal** is a general statement of what the project hopes to accomplish, or to contribute toward accomplishing, in the long term. It seldom has a time deadline attached, and may not be achievable through the efforts of a single project, although several projects or efforts together should contribute towards the goal. Often progress towards a goal can be determined only after some years of effort. A goal statement should be both **challenging** and **attainable**. All HIV education and prevention programs include some aspect of reduction in HIV transmission as their long-term goal. Examples of goals:

- To reduce the incidence of HIV/AIDS among young Hispanic men in East Austin, Texas.
- To reduce HIV transmission through needle-sharing among injecting drug users in Chicago.
- To ensure that Hispanics in Boston who engage in high-risk behaviors for HIV infection obtain HIV counseling and testing.

In general, goal statements are much less complex to write than objectives because goals need not provide expected project results in measurable terms. This specificity is required of objectives. (Since funders often have very specific funding criteria, the requirements for goals and objectives may vary. Always check with the funder when the meanings of goals and objectives are unclear.)

B. Objectives

Objectives are the near-term or intermediate accomplishments which contribute to the attainment of the goal. Objectives have the following attributes; they are:[3]

- **Specific**: Identify who, what, and where. Who is conducting the intervention? Who is the target population of the proposed intervention? Be sure to clearly define this population (e.g., persons with HIV/AIDS, incarcerated women, etc.). What type of intervention or product will be accomplished? Where will the activity or intervention take place?

- **Measurable**: Identify when and how many; specify both a timeframe for the completion of a project or activity *and* the number of clients to be served or services to be provided (make sure your stated activities or results can be measured to demonstrate that your planned activities were carried out or desired outcomes achieved). Measurement is the essence of evaluation and program planning is the place where evaluation is built into the project.

- **Reasonable**: Can be achieved within the specified time using available technology and resources.[4]

Objectives for carrying out a long-term HIV/STD project are better understood and appreciated when classified by type. The time invested in breaking down objectives by type in the beginning of a project will not only enhance the appearance of the project proposal, but will enable better management of activities, and hopefully minimize the occurrence of problems related to lack of planning during the project.

There are two major types of objectives:

- **Outcome objectives**: An outcome objective states the desired results of a program or intervention in measurable terms. It should be specific, realistic, and achievable during the project period. (See box on the next page for suggestions on writing outcome objectives.) For an HIV-related prevention and education project, results are usually stated in quantitative terms (e.g., a targeted level of client returns for test results within an HIV testing site, a specified increase in condom sales in a particular neighborhood). Examples of outcome objectives:

  - To increase from 40% to 75% within one year the proportion of individuals at La Clinica's anonymous HIV testing site who return for test results and counseling.

  - To increase from 40% to 80% the proportion of junior high school students from the South Bronx who answer correctly seven out of ten questions on an HIV/STD KABB survey by September 1, 1994.

- To increase from 20% to 50% within three years the percentage of injecting drug users (IDUs) attending South Side Drug Treatment Center who report using bleach and water almost always to disinfect their "works."

SUGGESTIONS FOR WRITING OUTCOME OBJECTIVES

- Begin with the word "to," followed by an action verb.
- In each objective, specify just one major result to be accomplished.
- Define the target population of the proposed intervention.
- Specify a target date for completion.
- State "what" will be achieved and by "when" -- it is not necessary to state "why" and "how."
- Be sure the objective is measurable so that you can verify whether or not it has been met.
- Be sure the objective is attainable given the agency's resources.

- **Process objectives**: A process objective specifies the completion of key activities or tasks essential to achieving an outcome. Taken as a group, process objectives are steps towards the desired results. A process objective must be specific, realistic, measurable, and time-phased. Examples of process objectives:

  - To assure that 50 high school parents complete a six-hour training course on HIV/STD disease and transmission within six months after project initiation.

  - To form a 20-member advisory group of teachers, social workers, HIV counselors and educators to assist in developing an HIV/STD curriculum for ninth graders within three months after project initiation.

- To conduct 48 hours of HIV/STD education to all ninth grade students of Madison High School within one full semester (January through June).

In writing an outcome or process objective, make sure you include expected measurable results. Ask yourself if you can measure or verify whether the objective has been met. If not, you probably need to specify more clearly the results you want accomplished, or add some criteria for measuring success. See examples below:

Outcome objective lacking measurable results:

> To develop and air a Spanish-language AIDS prevention radio public service announcement (PSA) which effectively reaches Hispanic teenagers, within 12 months after project initiation.

Outcome objective with measurable criteria added:

> To develop a Spanish-language AIDS prevention public service announcement and air it on three radio stations at times when the audience is predominantly Hispanic teenagers, reaching a total audience of at least 200,000 based on industry ratings, within 12 months after project initiation.

When developing your program objectives, it may be useful to list the measures to be used in determining success, as shown in the box on the next page:

GOAL/OBJECTIVES	CRITERIA FOR MEASURING ACCOMPLISHMENT OF OBJECTIVES
Goal: To increase knowledge about HIV/AIDS prevention among Hispanic teenagers. **Outcome Objective:** To air an AIDS prevention PSA that reaches at least 200,000 people consisting primarily of Hispanic teenagers within 12 months after project initiation. **Process Objectives:** 1. To develop a Spanish-language AIDS prevention PSA that targets Hispanic teenagers within three months after project initiation. 2. To contract with three radio stations which agree to air the PSA at times when their audience is predominantly Hispanic teenagers within two months after project initiation.	1. A Spanish-language AIDS public service announcement is developed and taped. 2. The PSA is aired by **three** radio stations. 3. The PSA is aired at times that ratings indicate that the audience is predominantly Hispanic teenagers. 4. Industry ratings indicate that the PSA has reached an audience of **at least 200,000** based on the times the PSA was aired. 5. All of the above have been accomplished 12 months after initiation of the project.

When setting outcome objectives especially, be realistic about what your HIV/STD intervention program can accomplish keeping in mind that these efforts must in the short term contribute to, or move towards, changing high-risk behaviors. Do not set objectives that cannot be met or set objectives that are really goals. (Remember that objectives should be measurable and obtainable.) For example, a goal of all AIDS education efforts is to produce changes in sex and/or drug-using behaviors that reduce the risk of HIV disease. Measuring behavior changes is often difficult and beyond the scope of what small community-based organizations can do considering their workload, limited funding and staff. Community-based organizations typically do not follow clients for a long period of time to enable them to assess direct behavior changes. These organizations can, however, implement, mobilize, and disseminate AIDS education and prevention resources which can, at some unknown point in time, lead to behavior changes. In the above example, the outcome objective was to air an AIDS prevention PSA — an activity that was measurable, obtainable, and contributed to — not accomplished — the ultimate goal of reducing high-risk behaviors.

Once the project goals and objectives have been finalized and have undergone sufficient staff review, it may help to keep these on a form exclusively for goals and objectives, for easy reference. If there are any questions about goals and objectives, it may be more efficient to pull out this form instead of pulling out the entire project proposal. This form should reflect all revisions or changes made to the project objectives. (See **Worksheet A.**)

III. TYPES OF PROGRAM EVALUATION

Program evaluation yields maximum benefit when it is applied consistently to all key stages of a project. In fact, community-based organizations are strongly encouraged to plan and design evaluation strategies *prior* to the initiation of the program, as part of the program development process. The following section examines three types of evaluation — design, process, and outcome evaluation.

A. Design/Formative Evaluation

The term **design evaluation**, also referred to as **formative evaluation**, describes all the evaluation methods used during and after program design, but *before* the program is fully implemented. Design evaluation also includes later assessments of the extent to which problems in implementation were related not to the process but to flaws in the original design. The information gathered from this type of evaluation can be used to understand the actual need for a particular intervention, help guide the initial design and implementation of the intervention, or improve an ongoing intervention.[5]

During the program design phase, consider some of the following questions:

- Why do we need this intervention approach versus another type of approach?
- If our agency is planning to implement a teenage pregnancy prevention program, what key activities and components must be included in this program? How do we effectively reach this audience? What staff qualifications do we need to ensure optimal job performance?
- Is our brochure written in language that is understandable and sensitive to the target audience? Are the messages clear and accurate?
- What high-risk behaviors are we trying to change in our program? What do we know about these behaviors? Why do persons engage in these behaviors?
- If our new program has been unsuccessful in attracting teenagers to our prevention sessions, what is wrong? Is our outreach design inadequate? Are we targeting the wrong population? Is something else wrong with our design — or are we not implementing it properly?

Design or formative evaluation can be conducted in many ways. Needs assessments, expert reviews, focus groups, key-person interviews, and documentation are possible approaches, as demonstrated below:

- Use **community needs assessments** to determine service gaps (e.g., absence of culturally and linguistically appropriate AIDS educational materials), identify target populations (e.g., recent immigrants), and identify potential partners among community-based organizations (e.g., youth centers, churches, schools, etc.). For example, information compiled from a needs assessment may reveal the need for a community-based organization to become a provider of HIV/STD prevention services for Hispanic teenagers.

- Use **expert reviews** to provide feedback on draft materials and program designs;

- Use **focus groups** to test prevention messages or materials. This could involve organizing a group of teenagers to provide feedback on a proposed public service announcement aimed at teenagers and using comments from the group to modify and strengthen the PSA before it is aired.

- Use **community interviews** and/or **key-person interviews** to obtain input on perceived service needs and priorities, as well as community attitudes about HIV/STDs; and

- Use **documentation** of client demographic information and program activities and its analysis, to review early implementation and compare it with projected activities and client populations. Also, make sure to thoroughly review and use the documented results of community needs assessments, focus groups, expert reviews, and other evaluation methods to improve training sessions, strengthen educational messages, and refine the overall program.

B. Process Evaluation

Process evaluation describes the methods that are used to assess whether the project has been implemented as planned, and whether the short-term process objectives have been achieved. It measures task completion and efficiency. This type of evaluation generally begins with the implementation of the intervention and continues for its duration to determine if interventions and delivery are functioning as planned and, if not, to direct necessary modifications. Three broad questions are addressed in process evaluation: What was done? To whom was it done? How was it done?[6] More specific questions answered through process evaluation might include the following:[7]

- Who is delivering the intervention? Are they delivering clear, accurate information? Are they sensitive to the needs of the target audience? Are they implementing the intervention protocols correctly?

- Is the project reaching the desired target groups? Are the projected number and types of individuals being reached and served?

- Do outreach workers, evaluators, and administrators fully understand the purpose and scope of the intervention? Can staff, especially those providing direct client services, agree in their descriptions of the interventions, how they will be conducted, what will be said?

- Are the tasks in the work plan being carried out on time, and within budget?

- Are there barriers to optimal performance among intervention workers (e.g., lack of support and training, lack of cultural sensitivity, lack of sufficient staff and/or lack of types of staff, stress and burnout, etc.)?

- How do clients feel about the program? Are the location and setting appropriate? Do clients feel comfortable in discussing the topic? Have you documented an increase in the number of clients coming to your agency since you implemented your new prevention program?

Process evaluation can be conducted using a variety of methods, including the following:

- **Post-session assessments, pre- and post-tests, informal surveys, games and other activities, case studies and role plays, and key-person interviews.** Applying one or more of these techniques can assess how well participants of an AIDS workshop understand the information and/or skills presented by the educators;

- **Community indicators.** Information such as the number of telephone calls made weekly to an AIDS hotline, the number of new client visits to an HIV/STD testing site, and levels of condom distribution and sales following a community AIDS awareness campaign provide some measure of the campaign's success in reaching the targeted community;

- **Administrative recordkeeping.** This includes such information as the number of HIV/STD presentations/seminars and/or street outreach sessions conducted, the location of intervention sessions, names of key staff conducting presentations and street outreach, the number of individuals reached through various interventions, and demographic characteristics about clients or descriptions of the target groups;

- **Narrative case studies.** A narrative case study is the documentation of all the major aspects of the project from beginning to end. Background information about why and how the project was implemented, the key staff and/or other organizations involved in the project, the major planning activities undertaken, problems encountered, and their resolutions are some examples of what should be included in such a report; and

- **Planned variation.** This method tests two interventions either simultaneously or at different times — whichever is most feasible — for a defined period of time to find out which intervention is most successful or beneficial. Usually, a standard intervention is tested against a slightly modified version.

C. Outcome Evaluation

Outcome evaluation assesses how well an AIDS activity or project (the outcome objective stated in the workplan) was carried out. There is a common misperception that in order for community-based organizations to do an outcome evaluation of HIV/STD projects, they need to show how and by how much behaviors of targeted groups changed as a result of the project. Actually, community-based organizations can conduct outcome evaluations without having to demonstrate direct behavior changes of target groups. For example, community-based organizations can measure how well target groups learned information taught during a series of AIDS education seminars through such evaluation techniques as surveys, role plays, and direct interviews with clients; they can seldom measure whether target groups are actually putting into daily practice what they have learned.

Outcome evaluation measures relatively short-term program results or benefits and determines "what is different" as a result of an intervention program. It determines the extent to which the outcome objectives of an intervention — those which were to be achieved during the year or during the project period — were in fact met, and also documents the *effects* of the intervention.[8] In an HIV/STD-related education or prevention program, outcome evaluation answers such questions as the following:

- What are the immediate effects of the program on clients? What results are pre- and post-tests showing in terms of education efforts' success in eliminating myths and providing new knowledge? Can participants demonstrate new knowledge, such as naming the major methods of HIV transmission? Can they demonstrate new skills, such as use of a condom? Can women role play appropriate methods for negotiating safer sex? Can injecting drug users demonstrate how to use bleach and water to clean drug "works"?

- Do clients *indicate* an intention to change their behavior on their post-test surveys?

- Based on short-term measures or limited follow-up with clients — using informal surveys, conducting direct client interviews, or counting how many calls for additional HIV/STD information were received — to what extent did the target group put the knowledge gained from a program intervention into practice?

- Do community measures indicate that clients are taking action based on what they learned in the intervention? Do HIV testing facilities report an increase in demand following your interventions, and when asked, do people requesting testing report that your program led them to come for testing? Are people requesting more information about HIV/AIDS following a PSA campaign suggesting that they call your agency for such information? Are agencies which provide bleach reporting increased demand? Are condom sales in your target community up?

Many approaches used for design and process evaluation can also be used for outcome evaluation. These include **pre- and post-tests, post-session assessments, focus groups,** and **games and other activities**.

IV. PROGRAM EVALUATION METHODS

Evaluation should be occurring at every project stage, whether in the design, early implementation, or post-demonstration stage. Ideally, evaluation should begin early in the project design phase and continue throughout the project's implementation. The aggregate data collected during the early stages are necessary for facilitating outcome project evaluation later.

Carrying out such evaluation requires not only understanding basic evaluation terminology and the components of an evaluation system, but also being able to use a variety of evaluation techniques. The task is to construct an appropriate evaluation system for your program by using a number of available "building blocks" — evaluation techniques which can each generate particular types of needed information, and when put together can provide a comprehensive and practical evaluation of a particular HIV/STD education and prevention program.

The descriptions below are designed to introduce a number of evaluation techniques which are likely to be useful in evaluating HIV/STD education and prevention programs. The purpose, potential applications, and steps or procedures for using each technique are explained. Before you begin to construct an evaluation plan for your program, you should become familiar with these techniques.

A. Needs Assessments

A needs assessment surveys a specific population in order to gather information about community needs and service/resource availability, and identify the services/resources that are not being provided. The data generated from a needs assessment can substantiate already known problems and/or identify new problems within a population or community. One should conduct a needs assessment to "test" the conditions before making major changes or launching entirely new services in an agency, neighborhood, or larger community. The structure of a needs assessment can vary, depending on the organization's size and resources. Because many Hispanic community-based organizations do not have sufficient staff or funds to conduct formal needs assessments, they often use informal methods. The following describes both types of needs assessments.

A formal needs assessment is usually a written survey of questions disseminated to a particular population — often a combination of residents, community-based organization representatives, and community leaders — for their responses. An informal needs assessment can be oral, using a group leader to ask pre-planned questions to an organized group, with an observer present to take notes on responses. It can even be more informal, where people from the community just tell staff what services are needed, or staff themselves determine needs based on their observations of clients and programs. When using informal

methods, always document the information, especially such information as the date, source of information (e.g., staff, clients, etc.), and description of needs, otherwise this information will be lost. Then, review and discuss this information at staff meetings and make sure to record any actions taken.

A needs assessment is most effective when the data are compiled, analyzed, documented in written form, and reviewed by key staff. The final report serves as a guide, indicating what services need to be changed or added to an existing program, or indicating the need for a new program. The following four points can help you design and implement a community needs assessment:

1. **Identify the questions to be answered.** These should include some of the following:

   - Who lives in the community? What are the socioeconomic characteristics of the residents? What are the sizes and characteristics of special-needs populations, such as youth, single mothers, and the homeless?

   - What is the extent, location, and accessibility of health and AIDS education and prevention programs within the community? What critical health-related needs are not being met and what are the effects of these service gaps on the community and its residents?

   - What are the perceived major problems within the community, and to what extent is there consensus about the relative importance of these problems?

2. **Review available information, and assess other data needs.** In order to answer these and other questions, many different types of information should be obtained and reviewed, through extensive use of secondary sources, and perhaps some individual interviews with agency directors and other community experts:

   - Information from any previously conducted needs assessments, whether done for the whole community or for a particular organization, entity, or subdivision of the community.

   - Federal, state, and local health department AIDS, STD, and other disease surveillance data.

   - Information about the economic base of the community, including business establishments and their employment profiles and products/services.

3. **Conduct interviews with community residents and leaders.** Given the limited resources of most community needs assessments, the most appropriate approach to conducting resident and community leader interviews is often to admit that

"generalizable" data based on a random sample probably cannot be obtained with the resources available, and then seek to obtain broadly representative case study data instead. This can be done in a variety of ways. The following approach has been successful in a number of locales:

- Decide what information you need that should be obtained through individual or group interviews or "focus groups."

- Develop a questionnaire which is reasonable in length, and contains primarily closed-ended questions (these questions elicit either "yes" or "no" answers which are much easier to tabulate) but also opportunities for comments (needed for depth of understanding).

- Identify major categories of individuals who should be interviewed — residents of varying age, sex, or socioeconomic status; businesspersons; human service agency directors and staff; public officials; religious leaders; educators; other identifiable groups.

- Decide how many interviews you can afford to conduct and allocate them among the various categories of individuals identified above. For example, for the residents subgroup, look back at the profile you developed of community residents, and develop a plan for interviewing people of varying characteristics. You might decide to interview 50 residents, allocated to fit community profiles based on age, race/ethnicity, income, etc. This is your sampling plan. The resulting data will not be statistically representative of the whole community, but you will get valuable case-study data.

- Test the questionnaire with several people of differing categories — and then revise any unclear questions and shorten if necessary.

- Train interviewers. For interviews with Hispanic residents, interviewers should generally be bilingual. Make sure the interviewers fully understand the questions and also understand how to carry out interviews and record data objectively, consistently, and carefully.

- Go to agencies, churches, and other entities and ask them to identify individuals with specified characteristics (based on your sampling plan) for you to interview.

- Carry out these interviews. Also interview the businesspeople, public officials, and other categories of individuals you probably identified.

- Now tabulate the data separately by type of person interviewed (e.g., community leaders versus residents), so you can compare responses by groups. Look for areas of consensus or disagreement concerning community problems and needs.

- Go back to several agencies and ask them to help you get together groups of people of various characteristics — a group of 6-10 youth, women with small children, etc. — and have a group discussion to further explore some of the problems and solutions suggested in the individual interviews.

4. **Analyze the data and prepare a report.** Once you have completed primary data collection as well as obtained available existing secondary data, you are ready to look over all the information, look back at the questions you wanted to answer, identify and fill any data gaps, and start reviewing your data. Organize the information by issue, in order to answer the major study questions. Use the following format as a guide for organizing the report:

   - Provide background on how the study was carried out, questions it was designed to answer, and any limitations of your approach.

   - Provide a community profile — physical characteristics, facilities and services, and residents.

   - Identify major community strengths and problems, and present areas of consensus and agreement, as well as disagreement, among residents and leaders concerning the nature and priority of problems and methods for their resolution.

   - Present detailed information on areas of special concern, such as HIV/STD education and outreach services. Deal with available resources, needs and gaps, and community recommendations for problem solving.

   - Provide conclusions which identify the implications and importance of your findings, and provide recommendations for action to solve the identified problems.

B. Expert Reviews

Consult regularly with experts outside your agency to assure accuracy and effectiveness of information to be presented to the community. All written and visual HIV/STD-related materials designed to educate Hispanic community groups or promote a specific project or workshop should undergo review by Hispanic experts working in the field.

For example, if your agency plans to offer support groups to Hispanic families, consult persons who are experienced in organizing support groups for Hispanics and understand the obstacles to family participation in support groups. If your client group includes injecting drug users, identify persons experienced in working with this group; if your program is focusing on Hispanic youth as peer AIDS educators, then contact persons knowledgeable about this role for youth. Outside experts can also assist project planners by reviewing English- and Spanish-language materials for content, language appropriateness, and accuracy.

WAYS TO USE EXPERTS TO EVALUATE PROGRAM DESIGN

- To serve on a panel which meets periodically to review project progress and interventions, and offer expert advice.
- To play a more active consultant role by developing interventions, designing flyers, games, role plays, or materials.
- To serve as problem-solvers when critical needs arise.

Use experts as part of a group or individually. If time constraints hamper participation in formal group meetings, individual experts can provide a variety of assistance at their convenience, such as reviewing proposals, materials, and intervention strategies. Using more than one expert can provide a range of perspectives. For example, experts can participate in a **Delphi** process, in which each person provides comments or written revisions to a project proposal or educational materials, then changes are made and the process is repeated, sometimes through several cycles, until the product is largely acceptable to the entire group.

An expert should have sufficient knowledge of and field and/or personal experience in the subject or in a closely-related subject. Expertise may be based on formal education or experience. Former and recovering substance abusers, persons living with HIV/AIDS, and parents of persons with AIDS can offer assistance and input on key issues to be covered in a case management or HIV support group program. When gathering a pool of experts, consider using not only researchers and heads of HIV/STD programs, but also social workers, teachers, STD clinic nurses, counselors, and other experts knowledgeable about specific populations (e.g., farmworkers, Hispanic subgroups) in order to obtain other perspectives. Be selective about whom you choose as experts for your project, always keeping in mind the type of input you want to obtain.

There are several excellent sources for identifying and locating experts. A good starting point for finding local experts is other nonprofit organizations in the same community. Other organizations may either have someone with the relevant expertise willing

to provide assistance or be able to direct you to other community experts outside the agency. Local or state health departments, high schools, colleges, and universities should also be contacted. For very specific issue areas, such as methadone treatment, you may need to first identify agencies working directly or indirectly in this area, such as a local health department's substance abuse unit.

In addition to contacting local and state agencies, you should also contact national organizations such as the National Council of La Raza (NCLR), which works closely with affiliate organizations all over the country. (NCLR is currently developing a directory of experts in various health and AIDS-related areas.) Be aware that it may take numerous telephone calls before you find the expert(s) that fit your specific project needs.

SOURCES FOR FINDING EXPERTS

- Nonprofit organizations in your community
- Local or state health departments
- High schools, colleges, and universities
- National organizations (e.g., NCLR)

When contacting potential experts, it is important to clearly identify the tasks involved, the type of expertise needed, the timeline for completing the task, and the projected amount of expert time required. Offer background information about the nature of your project and about your organization. Be prepared to pay fees for expert services.

C. Community Groups

Always seek input from community groups (e.g., local residents, clients and volunteers of community-based organizations, and staff of other local agencies) when designing or revising an AIDS education and prevention project for the community. They know best the unique concerns and problems of community residents, and kinds of services needed in the community. These groups can provide valuable suggestions about cultural issues to be aware of while conducting effective outreach in the community. Using feedback from groups can enhance the success of your program.

Located in the heart of the community, community-based organizations have the advantage of accessibility to many of the individuals that HIV/STD programs target. The challenge for the staff of community-based organizations lies not in finding individuals to serve as members of a group, but in organizing these individuals and groups in ways that will assist staff in designing and implementing the most appropriate programs for the

community or for assessing the quality of materials or training sessions. Community groups can provide input in the design of a teen peer AIDS educator program or an ongoing street outreach program targeting injecting drug users. Focus groups, community interviews, and demonstration or pilot sessions are three approaches for obtaining feedback from community groups. Careful staff consideration of the results of these approaches can enhance the project's responsiveness to the needs of the target groups. Although the results of these various approaches are informative, they cannot be generalized to a broader population.

WAYS TO USE COMMUNITY GROUPS FOR EVALUATION

- Focus Groups
- Community Interviews
- Demonstration Sessions

1. <u>Focus Groups</u>

A **focus group** is a carefully planned discussion among a small group of perhaps 8-12 people led by a trained moderator. The purpose of a focus group is to generate reactions to and opinions about concepts, approaches, and materials, including PSAs, posters, newspaper or magazine risk-reduction advertisements, flyers or brochures, outreach methods, or risk-reduction training approaches. The facilitator or moderator should be someone who is not involved in the design or revision of the brochure or project. This reduces bias that can result from opinions expressed by persons working directly with, or having a vested interest in, the project. The focus group should consist of individuals from the desired target population having certain common characteristics relevant to the topic involved. The more your focus group can relate to the topic or problem being

IMPORTANT STEPS FOR ORGANIZING A FOCUS GROUP

- Specify the purpose for organizing a focus group.
- Prepare a written outline or a guide for use by the moderator to assure that certain desired topics and questions are addressed during the focus group discussion.
- Develop a strategy for selecting focus group participants who are representative of the target group, and who have not seen the exact materials, workshop, or PSA before.
- Recruit a trained facilitator who is familiar with focus groups and is not involved in the project.
- Be aware of limited language proficiency or literacy among focus group participants.
- Plan to have at least two observers to take notes of comments and reactions during the session.

targeted, the more valuable the information will be. For example, to test the approaches or strategies for carrying out an AIDS education program for youth in a specific area, organize a focus group consisting of youth from the community you are targeting.

Focus groups provide a relatively low-cost way to test HIV/STD education and risk reduction concepts or materials before they are introduced to the public. A technique developed for marketing research — to test new products, packaging, advertising slogans, and approaches — its results are less precise than a large-scale survey, but it is also far less expensive and complicated to conduct. It can help a prevention program identify the strengths of and potential problems with its prevention efforts before committing itself to large-scale production or dissemination. For example, using a focus group to review a proposed PSA might result in a determination that the message is not clear — and will enable the project to revise it before sending out half a dozen tapes to local radio stations for widespread broadcasting. A national media campaign might use test marketing in one or several cities to test its PSAs; a community-based organization takes similar precautions when it tests a local PSA in a focus group. Similarly, if several different messages are being considered for a local media campaign, a focus group can be used to see how the proposed target group reacts to each, and suggest which approach seems more promising. The following case study illustrates the use of focus groups.

CASE STUDY

Using a focus group to conduct design evaluation

Staff of the "Positive Teen" project have been asked by the state health department to preview and provide comments to a bilingual video documentary which will be finalized and released in the next six months. The video is on HIV/STDs and is designed to educate Hispanic high school teenagers who are primarily English proficient and also speak and understand Spanish. Since a major activity of Positive Teen includes conducting presentations on HIV/STDs for high school teenagers, the AIDS educators are always interested in finding new materials and videotapes to use in their sessions. Because the video is aimed at Hispanic teenagers, the staff have decided not just to preview it themselves, but also to organize a focus group of teenagers to react to it.

In planning and organizing the focus group, staff need to consider and be able to answer the following questions (answers are based on the above case study):

What is the purpose for organizing a focus group?

Positive Teen staff wish to get comments and reactions on a pilot videotape from Hispanic teenagers, who are the target audience for the videotape.

What will be presented to the focus group?

A video documentary on HIV/STDs.

Who will moderate/facilitate the focus group?

Positive Teen staff have had a long-standing working relationship with a local community-based agency. The agency's project director and health services coordinator have agreed to assist Positive Teen staff since they have led focus groups in the past. (In this case, Positive Teen staff could moderate the focus group themselves since they are not directly involved in the design of the videotape, but they have never used a focus group before, so prefer to learn by observing the process.)

How will focus group participants be selected?

Positive Teen staff work closely with the guidance counselors in local high schools. A high school guidance counselor who is Hispanic and knows the Hispanic students well will recruit ten Hispanic high school students — equal numbers of boys and girls evenly divided between juniors and seniors — to participate in the focus group.

To what extent have these individuals been exposed to HIV/STD-related education and materials?

The ten students have received HIV/STD education by Positive Teen staff, but will be screened to be sure that they have not seen any video documentaries on the subject.

How will you assess whether the participants in the group have limited English language or literacy abilities?

Prior to the session, students will be asked individually which language they are most proficient in for the educational session. Four out of ten students indicated proficiency in both Spanish and English. Staff will also ask questions to assess literacy in both languages (e.g., Do you feel most comfortable reading (and writing) in English or in Spanish? What kinds of

materials do you enjoy reading the most — newspapers, magazines, novels, etc.? How often do you read?) Answers to these questions *suggested* to staff that students were most literate in English.

If there are participants with limited English language proficiency or literacy, how will these be addressed during the focus group?

Since there will be four Spanish speakers in the focus group, the focus group will be entirely bilingual. Two bilingual moderators will lead the group, and will trade off translating the questions to the group.

Other than comments from the group, will any other methods be used to assess the videotape?

Before the session, students will be asked to complete a short knowledge, attitudes, beliefs, and behaviors (KABB) survey which will be available in English and Spanish; staff will ensure that the survey requires not more than a fifth grade reading level. A post-session survey containing the same questions will be administered to students immediately following the videotape.

Who should be present at the focus group session?

The ten students: focus group participants
Positive Teen staff: observer, notetaker
Local community-based agency health staff: two bilingual moderators

The moderators should guide the discussion using a predetermined outline of questions, as shown on the next page. The focus group should last for a predetermined amount of time, with the moderators keeping the discussion on the topic. Once the moderators feel all the important points have been covered, they should conclude the session and thank all the participants. The moderators, observers, and staff of Positive Teen should schedule a meeting soon after to discuss the results of the focus group session. This should be followed by a written report which should guide the use of findings. (See page 30 for characteristics of a successful focus group.)

SAMPLE QUESTIONS FOR THE FOCUS GROUP

- What part(s) of the video did you enjoy most/least? Why?
- What did you think about the length of the videotape? Was it too short, too long, about right?
- What did you think about the characters in the videotape? How realistic were the characters in this documentary?
- What about the language used in the videotape? How easy or hard was it to understand? What parts were unclear or confusing?
- How easy or hard was it to understand the commentator? What did you think about his/her speaking pace and tone of voice? How convincing were the commentator's messages?
- What did you learn from watching this video?
- How did the video presentation change your feelings, attitudes, and/or opinions about HIV/AIDS and persons infected with HIV?
- What does it mean to "practice safer sex"?
- How do you think sexually active teenagers would react to adopting safer sex practices (if they don't already) after watching this videotape?
- What questions did the video leave you with? Should any particular questions be addressed in a group discussion following the video?
- How would you feel about viewing this video as a part of an AIDS 101 training seminar? Why do you feel that way?
- What kind of discussion do you think is needed along with the video, so its message will get across to teenagers?

CHARACTERISTICS OF A SUCCESSFUL FOCUS GROUP

- The objective of the focus group is clearly defined and manageable -- to decide among several different HIV/STD outreach strategies for runaway youth, to determine the clarity and attractiveness of a planned brochure or flyer.
- The moderator is experienced at facilitating group discussions and is independent of the project so that s/he is knowledgeable but does not bias the discussion with his/her own views.
- The discussion outline provides a blueprint for the focus group by stating the scope of the focus groups and the major questions or issues to be covered.
- Key program staff either observe or listen from another room.
- The focus group environment is well-selected -- it is comfortable, quiet, and allows for good-quality audio taping; refreshments are served.
- Audio-visual equipment works properly.
- The group composition represents the target group of the project; if there are several target groups, multiple focus groups are used so each group is as homogeneous as possible.
- The group is a manageable size, large enough to provide for a variety of views but small enough that everyone participates in the discussion; usually 8-12 participants.
- The session is carefully scheduled and managed. Usual stages include an introduction, a warm-up to introduce group members, general topic presentation and discussion to obtain broad opinions about HIV/STD prevention; presentation of the concept, and specific discussion of reactions, with both individual opinions and group discussion; a closing and a thank you.
- The session is of an appropriate length, one and a half to two hours maximum.
- Focus group participants receive a reasonable fee for their participation (usually $25 or $30; an extra $5 might be added for an evening session).
- Discussion among program staff, moderator(s), and observer(s) follows each focus group.
- Once all focus groups have been completed, a comprehensive report is prepared.

2. Community Interviews

A community interview is a less formal version of the focus group. This technique involves a similar discussion approach, but participation is relatively open. Where a focus group involves the actual target group, the community interview involves a mixed group of individuals — often all ages, genders, sexual orientations, and racial/ethnic backgrounds. For instance, a community interview may involve a group of clients of a particular health/human service program, all students in a class, or a group of parents of Head Start children in a particular center. Because of the greater diversity of individuals, a community interview can involve a larger group than a focus group. A good-sized group is anywhere between 15 and 30 individuals.

Similar to the focus group, a community interview involves a well-structured discussion session. At least two group leaders facilitate the discussion using a carefully developed interview guide. The community interview should be planned and conducted with care, and its proceedings should be both taped and recorded in writing. Because a community interview is informal, its results should be viewed as providing valuable insight but not information which can be projected to a broader population. Community interviews are recommended for assessing PSAs, videos, television documentaries, posters, games, role plays, skits, and all other written/visual materials and methods used for educational purposes. The materials to be tested can be directed at specific population groups (e.g., Hispanic males, teenagers, etc.) or can be general in focus.

CASE STUDY

Using a community interview to preview an HIV/AIDS skit

Positive Teen staff coordinated a group of community volunteers consisting of teenagers, high school teachers, and parents to preview and provide feedback to an HIV/AIDS education skit. At the end of the skit, the facilitator -- a local high school teacher -- asked the group the following questions about the skit:

- What is this skit all about?
- Which character roles did you like best/least?
- What messages did you get from this skit?
- How is this skit useful to teenagers? To parents? To teachers?
- How would you improve the skit to make it more effective in getting its message across? (See **Worksheet B.**)

3. Demonstration Sessions

A **demonstration session** is a "practice run" or a "pilot session" of the actual session you are planning to conduct. It is the opportunity to test how HIV/STD-related presentations and seminars "go over" with participants who represent the desired target group, before the sessions are widely or repeatedly implemented. Once the various components of the seminar — agenda, curriculum, written and/or audio-visual materials — have undergone sufficient review using one or more assessment techniques described above, you should do a demonstration session. The results of the session may indicate a need for either significant redesign or minor modifications and fine-tuning. Even when you have *not* used other assessment techniques such as experts and focus groups, you can and should still conduct a demonstration session as long as you allow ample time to make any necessary changes. Clearly, the benefits will be greater when several evaluation techniques are used on a project.

You should do a practice run of all HIV/STD-related sessions. These could include slide/video presentations, theatrical presentations, in-house training workshops, and other HIV/STD presentations for use in schools, beauty parlors, homes, jails, or street outreach sessions. Because a demonstration session is a pilot of the actual session, conduct it in the same way you plan to implement the ongoing sessions. Select participants who fit your target audience; use the person who will actually facilitate the seminar or workshop; have ready the curriculum, agenda, and other materials you plan to use; make sure to hand out any surveys and/or forms you plan to use, such as pre- and post-tests and assessments; and when possible, conduct the session in the actual setting where the activity is to take place. Plan to have at least two observers present who do not take part in the discussion. They should be knowledgeable about the topic but not necessarily involved in the specific project that is being tested. Their primary role is to take notes on how the session proceeds and any problems that arise during the session. Problems that involve participants, facilitators, materials, and even the location should be documented on a pre-developed form (non-participant observation form). After the session, assess the results carefully from both the participant and the agency perspective, and revise the seminar based on that assessment.

BEFORE A DEMONSTRATION SESSION, PREPARE

- Clear objective(s) for the proposed activity (e.g., by the end of the AIDS education session for adolescent parents, 80% of the participants should be able to identify at least two ways to reduce the risk for HIV infection.)
- A group of participants representative of the target group.
- The written presentation as planned for implementation; for a formal seminar, this means a full seminar package, including objectives, agenda, group exercises, and reference materials.
- A pre- and post-test to measure knowledge, attitudes, and behaviors (including reported plans for behavior change) -- either written or oral, whichever is appropriate for the group.
- Post-session assessment forms or a list of questions for oral interviews, to determine participant reactions to the presentation methods and content.
- Non-participant observation forms for use by persons knowledgeable about HIV/AIDS but not directly involved in the project.
- A detailed session assessment form for use by the facilitator following the demonstration session.

AFTER THE DEMONSTRATION SESSION

- Have a detailed post-session staff meeting to fully assess the presentation.
- Aggregate and assess the results of the session based on pre- and post-tests, assessment forms, and non-participant observation forms.
- Hold a debriefing session with the facilitator, observers, and key staff, to review results, and make decisions about how the presentation ought to be revised based on the demonstration session.
- Make appropriate changes in the presentation or seminar -- in terms of objectives, content, agenda, presentation methods, and exercises -- to overcome problems identified during the demonstration session.

D. Observers

An **observer** is someone who is present at a presentation, seminar, or other HIV/STD-related educational activity involving community groups or individual clients, for the purpose of recording comments, reactions, criticisms, or problems relevant to the activity. This person can provide useful insight into the quality of a presentation or intervention, in terms of its content, clarity, delivery, and appropriateness for the target group.

In any HIV/STD intervention, the staff or volunteers with primary implementation responsibility — presenter, facilitator, counselor, or media specialist — are likely to be fully occupied in carrying out the session or other intervention. Until the intervention has been repeated several times, they will have to concentrate on that process. This means they may not be fully aware of the reactions of participants or of the strengths and weaknesses of the presentations of others. In addition, it is difficult for most people to take an objective look at an intervention they have designed and are implementing.

A carefully selected observer can be helpful in providing an "outsider's" perspective. An observer may be a **participant observer** who is a member of the target group but is asked to pay particular attention to how the intervention is implemented, or a **non-participant observer**, who may be an expert on HIV/STD interventions but is not directly involved in the presentation or project. Non-participant observers can be persons working in other areas of the organization, volunteers, or community experts. The number of observers depends on the size of the group. One observer should suffice for a group of ten, and two or more observers may be necessary for a group exceeding this size.

Observers should be used whenever community groups are brought together in a specific setting to provide input on training curricula, brochures, videotapes, and other materials. They should also be used during process evaluation for ongoing HIV/STD education and prevention activities. For instance, observers could accompany AIDS educators periodically when they conduct outreach activities in neighborhoods and schools, in order to provide the educators with feedback on their presentations. The following example illustrates one possible use of observers:

CASE STUDY

Using observers as evaluators during a demonstration session

Staff of PARENTEEN are almost ready to begin implementing an HIV/STD education/skills-building workshop which they have been designing for the last six months. In preparation for a demonstration session of the workshop, staff are recruiting a participant and a non-participant observer to help evaluate the workshop before its full implementation. The participant observer will be recruited from the pool of participants who have already agreed to attend the demonstration session, and the non-participant observer will be one of the agency's volunteers.

As part of the recruitment process, an informal meeting is scheduled between the observers and a PARENTEEN staff person who works outside of the HIV/AIDS component, is informed of the proposed workshop, yet has had no involvement in its design. During the meeting, the staff person provides general information about the demonstration session and explains the functions of the observers. These meetings provide the staff with a good indication of which individuals will be effective observers for the demonstration session. PARENTEEN staff seek individuals who meet the following criteria:

- Not involved in the project or presentation to be given;
- Knowledgeable about the topic to be presented;
- Comfortable with notetaking;
- Familiar with and attentive to group dynamics; and
- Impartial during the session; in writing notes, the person is as objective as possible and refrains from imposing personal viewpoints.

Once the observers have been recruited, the demonstration session of the workshop is held. The observers arrive at the session early so that they can take notes of any problems before the session begins (e.g., any missing materials or equipment necessary for the session, unclear directions to the site, etc.). During the session, the observers take notes of all major comments and questions from the group regarding the written/visual materials, games and exercises, and level of group participation. After the session, PARENTEEN staff meet with the observers to review their notes and discuss other observations about the workshop.

E. Individual/Group Assessment Methods

When planning training sessions, presentations, or workshops for groups, plan to include some methods for assessing how well the groups learned the information and skills taught during the session. Identifying the areas of a workshop or other activity that need improvement or redesigning, as well as those that are effective can benefit the entire project and its target groups. Methods for obtaining this information from the participants, directly and indirectly, are described below; these include written assessments, pre- and post-tests, surveys, and more creative approaches such as games and other activities, case studies and role plays, and key-person interviews.

1. Post-Session Assessments

Post-session assessments are usually one- to two-page survey forms which are handed out to participants at the end of a workshop or training seminar. The assessment seeks to determine whether participants learned certain information, rejected stereotypes or myths, or changed attitudes as the result of a specific intervention. This assessment tool uses participants' feedback to evaluate the intervention. Their responses provide some indication as to the quality and possible effectiveness of the intervention session.

METHODS FOR ASSESSING INDIVIDUALS/GROUPS

- Post-Session Assessments
- Pre- and Post-Tests
- Informal Surveys
- Games and Other Activities
- Case Studies and Role Plays
- Key-Person Interviews

Every workshop, training seminar, or other scheduled and formalized prevention presentation should include some form of post-session assessment. Where possible, a written form should be used. Depending on the group's needs, the form should be available in both English and Spanish. If you use a written form, be sure to indicate that anyone who would prefer to be interviewed in private has the option of requesting this. (This is one way to deal with persons who have limited literacy without embarrassing them.) Where many of the participants are unlikely to be able to complete a written form, then either all or a sample (every third participant, perhaps) should be interviewed orally. Or, the participants can be given numbered answer sheets so they can simply circle the appropriate numbered response to a series of closed-ended questions asked by the presenter (e.g., response number one, two, or three to a particular question). Entirely oral assessments are possible if the group leader requests that participants raise hands to respond to certain questions, and a sufficient number of observers are present to record responses. Regardless of the method used to administer the assessment, the following additional considerations should guide its development and use:

HINTS FOR DEVELOPING AND USING POST-SESSION ASSESSMENTS

- Always allow sufficient time (at least fifteen minutes) at the end of the session for assessment.
- Keep the assessment anonymous. Many individuals may not fill out the form or may not give honest responses if their names are attached to the assessment.
- Stress in the session the importance of completing the assessment.
- Use simple, clear, and culturally appropriate language.
- Include in the assessment a question about the extent to which participants have learned new information, skills, or attitudes about HIV/STDs.
- Include a question on how participants plan to apply or use what they have learned. Such questions are "surrogate measures" for actual measurement of behavior change. For instance, inquire whether participants plan to teach others about HIV/STD transmission; or whether they plan to change their own behavior or try to get family members or friends to change theirs.
- Use mostly closed-ended questions, so the form can be completed quickly.
- Include some open-ended questions so that participants can comment on best and worst aspects of the session (e.g., trainer, presenter, materials, etc.), provide other comments, or make recommendations for improving the session. (See **Worksheet C**.)

2. Pre- and Post-Tests

Pre- and post-tests are usually short surveys designed primarily to assess changes in individuals' responses to questions regarding HIV and other STDs. Pre- and post-tests follow many of the same "rules" as post-session assessment forms, but they are administered twice. Through a series of targeted questions, a **pre-test** measures an individual's knowledge, attitude, and sometimes reported behaviors related to HIV/STD *before* the actual intervention. The **post-test**, given *after* the intervention has taken place, assesses whether an individual has gained new knowledge about HIV/AIDS and other STDs, which may lead to changes in both attitudes about the disease and/or towards people infected

with the virus, and in a decision to change sex practices and/or drug-using behavior. The basis of measurement is the change in response between the pre-test and the post-test. Results of pre- and post-tests can help project staff:

- Develop a general understanding of a group's baseline knowledge and attitudes about HIV/STD transmission, sexual and drug-using practices, and prevention of HIV/STDs.

- Identify what participants learned and what they didn't learn, and whether they plan to change high-risk behaviors.

- Determine whether the presentation works. If post-test responses show little or no change from pre-test responses, then it is important to try to identify and resolve the problem(s) for future sessions. The problems may be related to the curriculum, the format, the presenters, the delivery of the presentation, etc.

- Make revisions for the next intervention session.

Written pre- and post-tests may not be appropriate for groups who are not regularly exposed to a learning environment and who have low literacy in English or Spanish. In such cases, pre- and post-tests can be conducted orally in small group settings, or other creative methods can be used (e.g., use of index cards with pictures, role plays, etc.). These tests may be most effective for groups such as high school teenagers, who regularly must read and write. Groups who are limited-English-proficient and literate in Spanish should be provided Spanish language pre- and post-test versions.

Pre- and post-tests offer insight as to whether an intervention is working. These tests cannot establish conclusively that it was the intervention that led to any recorded changes in knowledge, attitudes, or planned behaviors. Such conclusions are usually based on findings from using a case-control group, where a case — the group of individuals receiving a particular intervention is compared to a control group — the group of individuals not receiving a particular intervention. Without a control group, you cannot establish that it was your program and not some other influence (e.g., TV program, conversation with a friend, etc.) that made the difference.

SEVEN WAYS TO ENSURE THE EFFECTIVENESS OF PRE- AND POST-TESTS

1. Check all questions and responses with several experts to be sure that alternatives are appropriate and "correct" responses are accurate.

2. Test the draft forms with individuals from the target group, to be sure the questions are clear and understandable.

3. Code each set of pre- and post-test forms so that you can compare the responses of the same individual before and after the intervention.

4. Explain the importance of the tests at the beginning of the session, and have the pre- and post-tests completed individually. If you are using a written form, make sure to collect the pre-tests so they are not changed during the session.

5. Use primarily closed-ended questions. If you want to minimize guessing, give instructions that ask people not to guess if they really don't know the answer, and provide a "don't know" response. If you want people to guess, don't give them this alternative.

6. Make sure questions asked in pre- and post-tests directly correspond to the information presented at the session. This is important to consider when borrowing questions from other programs.

7. Match pre- and post-tests for individual participants and tabulate changes, as well as tabulating all pre- and all post-tests and comparing them. Then use the results to identify areas in which the intervention is and is not getting the point across -- and refine the presentation or seminar to strengthen problem areas.

3. Informal Surveys

Informal surveys can be used to obtain information from participants in program interventions and community residents, where formal KABB studies and follow-up surveys using probability samples and structured questionnaires are not feasible. Results of informal surveys should give some indication of a group's knowledge but cannot be generalized to the larger population.

An **informal survey** is usually administered to a relatively small number of people — perhaps 30 to 50. Respondents are generally selected through "quota" sampling; that is, the population is divided into target groups (e.g., injecting drug users, teenagers, women of childbearing age, etc.), and a pre-determined number of respondents are chosen from each target group to ensure a representative sample of participants.

To obtain baseline data on knowledge of HIV/STDs from groups, such as clients of your agency, a survey could be provided to each person (or every third person) who walks into the agency on a given day or over a one-week period. Interviewers should be responsible for handing out the survey after the person has gone through the intake procedures. The interviewer must explain the purpose and importance of the survey, stress that it is confidential, and request the participant to complete it. The interviewer should be sensitive to persons with limited English proficiency and have surveys available in Spanish. Persons with limited literacy can be interviewed individually by the interviewer, using the questions from the survey. The surveys should be anonymous, since the purpose is to obtain aggregate information. In order to identify the types of services used by individuals, "purpose of visit" should be one of the questions at the beginning of the survey.

Informal surveys can also provide follow-up information on people who participated in a particular intervention. Interviewers can work with agency recordkeepers/intake staff to obtain a list of names of the individuals who have received on-site HIV/STD education within the past three months. A note or symbol of some kind could be made in their records indicating that these individuals should receive surveys on their next visit. The interviewer is responsible for administering the survey to the person, who can complete the survey while waiting to meet with a staff person.

Community or "convenience" sampling is another option, in which the interviewers go to a site where an intervention has been carried out — drug treatment clinic, STD clinic, Headstart Center, or community-based organization — and talk to people who come to the facility and have been involved in the intervention. As a matter of courtesy, interviewers should first discuss the project with directors of the respective organizations and/or clinics and seek their approval and input on how best to conduct interviews.

While results will not be statistically significant using either approach, informal surveys can provide valuable information about whether interventions seem to be making a difference.

A SUCCESSFUL INFORMAL SURVEY

- Uses a relatively brief, structured survey questionnaire which focuses on a limited number of issues, using primarily closed-ended questions but also including some open-ended ones.
- Is implemented by a small number of well-trained interviewers, but with more flexibility than in a formal survey; so long as they obtain responses to the key questions, they may add open-ended questions to follow up a response or clarify an issue.
- Is administered to a small number of people and not assumed to represent the responses of a larger population.
- Usually focuses on one intervention targeting a particular group rather than a whole range of interventions involving a wide range of target groups.
- Generates qualitative data indicating program results, strengths, and weaknesses, and can be used to refine the intervention approach and document promising approaches.

4. Games and Other Activities

Creative techniques must sometimes be used to assess the effects of a prevention intervention. When participants in a training session or some other kind of education intervention lack basic literacy in English or Spanish, a written survey in either language will serve little use. A game or some other form of active feedback may be the best method to gauge the extent to which participants have learned specific information. Games are especially valuable because they require active involvement of the group, and may require participants not just to state but also to apply new knowledge. This may encourage behavior change. Games can be useful feedback tools even where literacy levels are high, since they provide an active, interactive, and often entertaining means of obtaining information about what was learned and how it is likely to be applied to real-life situations.

In using games to evaluate the extent to which new knowledge, attitudes, or skills have been learned, it is very important that:

- The games are played in small groups or in a way that assures that most or all group members participate — so the learning of all can be assessed.

- A sufficient number of staff or other observers are present to record the individual responses of the participants, so that as little information as possible is missed. Taping can be helpful if the system is of sufficient quality that everyone can be heard, and if someone systematically extracts the appropriate information from the tape. (You should advise participants that you plan to tape their discussions.)

- The situation — game, role play, or case study — is carefully planned and explained to the group. It is important that the facilitator or moderator take time at the beginning of the session to thoroughly explain the game or other activity to assure that all participants understand what to do. The facilitator should also explain any "ground rules" that all participants must adhere to (e.g., participants must be respectful of one another and refrain from criticizing each other's comments, opinions, or questions, etc.). If the group is literate, the facilitator can write down the main points and "ground rules" of the game on a blackboard or easel pad for easy reference. Before beginning the game, the facilitator should ask if there are any questions, and even ask the group questions about the instructions to make sure they understand.

The following exercise modifies and builds upon a game used with an African-American women's program in Chicago run by the Kupona Network:

▶ Your session is designed to teach women (or some other target group) the ways in which the HIV virus can be transmitted. At the beginning of the session, write five names on the board, and ask members of the group to work in pairs to identify five different ways that each of them might have contracted the HIV virus. If you find that no one is identifying perinatal transmission, you might point to one name, saying "This person has AIDS, but has never had sex, never used injecting drugs, and never had a transfusion; how did s/he get AIDS?"

A non-participant observer should be recording the responses of each pair. Answers to such questions will provide staff a good sense of pre-session knowledge about HIV transmission. At the end of the session, divide the group into pairs again to assess whether they have learned the various methods of transmission. This time, staff should use a slightly more complicated version of the game:

▶ Here are seven people: Miguel, Juan, Maria, Jose, Cecilia, Jenny, and David. Eight years ago, only Miguel was HIV-positive; now all seven of these people are HIV-positive. Explain the relationships between these people and describe how each of the other people might have become infected, directly or indirectly, from Miguel. Include each different type of transmission.

There are many different "answers" to this; a typical explanation would be as follows:

Miguel had sex with Juan who contracted HIV through their homosexual relationship. *Method: anal intercourse between two men.*

Juan was a person who had both male and female sex partners, and he passed the virus on to his girlfriend, Maria, through their sexual relationship. *Method: virus was transmitted from a man to a woman through vaginal intercourse.*

Before the blood supply was being routinely tested, Juan gave blood, and Cecilia got the HIV virus from his blood when she had an emergency transfusion after an auto accident. *Method: blood transfusion.*

Maria broke up with Juan and married Jose, who got the virus from her through a heterosexual relationship. *Method: virus was transmitted from a woman to a man through vaginal intercourse.*

Maria, who didn't know she was HIV-positive, got pregnant and gave birth to Jenny, who was born with the HIV virus. *Method: perinatal transmission from a mother to her unborn child.*

Jose was an injecting drug user, and David used one of his dirty needles and got the HIV virus. *Method: needle-sharing by injecting drug users.*

This game can be taken one step further if you have been teaching about positive risk-reduction behavior. The session leader might discuss one set of responses like those above, and then ask the group: **"How could each of these transmissions have been avoided? — what risk-reduction actions could have been taken?"** Responses should include the following:

- The blood supply is largely safe today. However, anyone who is or thinks s/he might be HIV-positive certainly should not donate blood.

- The probability of transmission through sex — between men or between a man and a woman — could be reduced by use of latex condoms. Reduction of casual sex will also reduce this risk factor.

- Using bleach to sterilize used needles and using new needles will minimize the probability of transmission through dirty needles. Getting drug treatment which leads to elimination of injecting drug use is, of course, a much better long-term solution.

- HIV testing would tell individuals whether or not they are HIV-positive, and would enable HIV-positive and -negative individuals to receive counseling, and minimize transmission possibilities by limiting the number of sexual relationships and using condoms.

- The only way to prevent perinatal transmission is for an HIV-positive woman not to become pregnant.

5. <u>Case Studies and Role Plays</u>

Another active feedback method is the use of **case studies and role plays.** If a session is designed to help young adults and teenagers learn about HIV/STD transmission and about ways to reduce their own risk, a closing role play might put the participants in pairs or other small groups (four or five persons at most) and give them a case study and role play. For example:

> You are a young woman on your third date with a good-looking guy. He has indicated that he wants to begin a sexual relationship. You know that he was taking drugs a couple of years ago, but has since stopped. What do you do?

You might have the entire group discuss different approaches and decide what they would do. Or you can do a role play by having one person in each small group role play the woman, another the man, and have two others serve as observers, responsible for remembering or jotting down the major points each person makes in the role play. (You can even have a third observer focus on their interaction, non-verbal communication, etc.) Staff should be observing each small group and recording the extent to which the groups apply positive risk-reduction techniques which reflect or build on material presented in the session.

Another approach involves presenting statements and asking small groups to respond to them. The statements can be read to each small group by a facilitator if literacy rates are low. The purpose is to see if information presented in the session was learned and is applied appropriately to real-life situations. For example, the following statements might be used:

> *Statement from a man whose male sex partner has just been diagnosed with AIDS, and who says he doesn't need to get an HIV test:* **I can't have AIDS because I am not gay. I just had Dan as a sex partner because my wife lives in Mexico, and I didn't want to cheat on her. We have three children.**
>
> *Response sought:* **You get HIV/AIDS because of your behavior, not your values. Any man who has sex with another man that is HIV-positive is at risk for HIV/AIDS and should be tested.**

Statement from a woman whose partner is an injecting drug user: **I am afraid he might have the HIV virus, but if I ask him to wear a condom he will get very angry at me, and might beat me or leave me.**

Response sought: **Negotiating safer sex practices with your partner can be a complicated and difficult process. Ultimately, you need to remember that there is no cure for HIV/AIDS, so preventing this disease is critical. If you have unprotected sex with someone who may be HIV-positive, you are literally risking your life. You may be able to encourage him to get an HIV/AIDS test, or to change his behavior, to stop injecting drugs, or to use only clean needles. You may be able to persuade him to use a condom for the sake of protecting you and any future children, or argue for condom use as an effective birth control method. Realistically, your choice may be between breaking off the relationship and risking your life.**

Television dramas/stories can also provide an effective role playing situation that can help your target group learn about high-risk behavior. On week nights, many Hispanics, particularly women, like to watch *telenovelas* (soap operas) broadcast on the Spanish-language channels. These are popular forms of entertainment and serve as topics of conversation. *Telenovelas* often depict real-life situations involving problems arising in relationships and family. HIV/STD education and prevention sessions targeting Hispanic women could develop a videotape presentation using one or two episodes from a popular *telenovela* for discussion. Staff and community experts should first preview the *telenovela*, identify important issues around HIV/STD for discussion, and prepare structured questions *before* presenting the videotape to the target group. The responses to focused questions can provide an understanding about the group's HIV/STD-related knowledge, including myths and stereotypes about AIDS. The videotape could be presented twice during a session, before and after the group has received HIV/STD prevention and skills-building information. Discussions following the videotape presentations would indicate whether the information has enhanced the group's knowledge and reduced myths and stereotypes about HIV/STDs.

An exercise following the video could have participants either as a group or in small groups identify characters who may be at risk of HIV/STDs and explain why and how these characters could contract the disease. Other AIDS-related issues could be explored as well, such as the importance of family support and understanding for people who are ill, information about community health and mental health resources for persons with HIV/AIDS, raising confidence and self-esteem in relationships — all critical issues that increase awareness and can reduce the incidence of HIV/AIDS. AIDS educators could pose questions based on characters from the *telenovelas* to groups for discussion. For example:

Pepe recently discovered that he had tested positive for HIV. He has been very depressed and has not revealed his HIV-positive status to any of his sex partners or family members. He did reveal his status to you because you are his closest friend. What kind of advice would you offer to urge Pepe to notify his sex partners?

Pepe especially fears the type of reaction he will get from his family members. What advice could you provide him? Are there specific places you would recommend he go for assistance?

The written version of the *telenovela*, the *fotonovela*, is also a common form of recreation among many Hispanics, particularly women. When your group is fluent and literate in Spanish, the *fotonovela* can be used as an educational tool in seminars on HIV/STDs. *Fotonovelas* are short, comic-book-sized narratives with black and white or cartoon-style pictures. The narrative tells a story and usually focuses on two or three main characters, one of whom may be at risk of HIV infection or may have contracted AIDS. The following exercise is one way to use a *fotonovela* during an HIV/STD education and prevention session:

Allow the group 15-20 minutes to read through a *fotonovela* on HIV/STDs. Then have the group come up with at least three main characters of the *fotonovela*. Break up the group into three small groups: one group will be Character 1; the second group, Character 2; and the third group, Character 3. Each group should identify specific ways in which the group's particular character contributed or helped to:

1. Increase or decrease either their own or someone else's risk for HIV/STD transmission.

2. Dispel misconceptions or myths about HIV/AIDS.

3. Increase awareness of other STDs besides HIV/AIDS.

The following are some examples:

Carmelo and Juan go the local tavern after work. After several hours of drinking, Juan begins to flirt with a stranger. Juan expresses to Carmelo his intent to continue having fun with the stranger tonight. Carmelo gives Juan a pat on the back and orders another round of drinks for the three of them. Carmelo's encouragement to continue drinking increases the likelihood that Juan and the stranger will have unprotected sex, which can lead to infection with HIV/AIDS or other STDs.

During a conversation between Liona and Pablo, Pablo mentions that he has stopped swimming in pools because of the fear that he will get AIDS. Liona interrupts and tells him that he cannot get AIDS by swimming in pools, it is the exchange of body fluids -- either of infected semen or blood -- that leads to infection with HIV/AIDS. In this case, Liona is trying to dispel misinformation about the transmission of HIV/AIDS.

Linda is worried about her good friend Melissa who has had unprotected vaginal sex with three different partners in the last two months. After Linda raised the subject of HIV/AIDS, Melissa assured Linda that none of her sexual partners have used injecting drugs or have had sex with other males before. Consequently, Melissa feels no need to get HIV-tested. Linda cautions her friend that heterosexuals can transmit AIDS, and also, AIDS is one of many diseases that are transmitted sexually. Other non-HIV sexually transmitted diseases are extremely common and if left untreated can cause permanent damage to reproductive organs. Not only HIV, but also diseases such as gonorrhea and syphilis could have been transmitted to her sexual partners by other women, thereby placing Melissa at risk. Linda finally succeeds in getting her friend to visit an STD clinic. In this case, Linda is trying to dispel myths about the transmission of HIV/AIDS and increase Melissa's awareness of other STDs.

6. Key-Person Interviews

Key-person or **key-informant** interviews are useful for obtaining an in-depth understanding about the effectiveness of ongoing interventions or key issues to consider in developing or improving interventions. This method involves developing an interview guide or checklist specifying major topics and issues to be covered, but not structured questions. This checklist then serves as the guide for carrying out an in-depth interview with a small number of individuals who have had personal experiences with, and/or are knowledgeable about the problems and groups being targeted by a program. Key-person interviews can provide a quick assessment of: (1) the issues to be considered in designing a new education and prevention approach, (2) how a prevention approach is working, or (3) major variables to investigate further in an informal survey or pre- and post-test.

Key-person interviews are useful only when the individuals interviewed are in fact knowledgeable and willing to provide detailed information. Although the interviews cannot provide information for generalization to a larger population, they should provide a wide range of perspectives on the program and the issue (e.g., key issues that should be considered in implementing a peer AIDS educator program, effective HIV/STD outreach methods for gay Hispanic youth, etc.). Therefore, it is important that the individuals to be interviewed are carefully selected to assure various points of view, experiences, and concerns. This may mean people of varying income and occupational groups, people who are considered likely to engage in, or be knowledgeable about, different types of high-risk behaviors, and staff of organizations as well as program clients, etc. The appropriate categories will depend on what is being assessed.

Because the interview is a guided discussion without closed-ended questions, it requires an interviewer who is extremely knowledgeable about the project, and trained to probe for information without presenting his/her views in a way which might bias the responses. The interviewer should take detailed notes of the responses to the questions and might also tape the session for back-up. After the session, the notes should be compiled into a final interview report. It may be necessary to call the individual back for more information.

A series of key-person interviews will generate in-depth qualitative information about a project, information which will typically need to be supplemented with other project data such as focus group results, post-session assessments, and perhaps informal surveys. The results of such interviews can also help program staff select the issues to be covered in focus groups, assessments, and surveys, and can help frame the questions appropriately. The following example illustrates the benefits of this approach:

CASE STUDY

Using key informants to obtain feedback on a new street outreach program

Three months ago, Project REACH implemented a three-year HIV/STD street outreach program targeting Hispanic injecting drug users (IDUs) in the Pilsen area. As part of their evaluation efforts, staff will conduct a series of key-person interviews throughout the year to get feedback on their approaches and strategies for conducting street outreach. The first set of interviews will assess primarily the information being disseminated by outreach workers. Staff will recruit key informants representing former prostitutes, HIV counselors, recovering drug addicts, and street outreach workers from other agencies.

Project REACH will have available for the key informants the written versions of the types of information generally provided to all clients during street outreach sessions, as well as any pamphlets distributed. In addition, key informants will view a videotape showing outreach workers role playing several street outreach sessions. This will provide key informants with a better sense of Project REACH's street outreach sessions. The following questions will be used as an interview guide:

- Are the outreach workers providing the kinds of information that will be useful to Hispanic IDUs?
- What other types of information should be provided to Hispanic IDUs?
- What do you think about the information being delivered by outreach workers? Is it understandable, clear, and appropriate for the Hispanic IDUs living in the Pilsen area?
- Are the outreach workers providing correct information about HIV/STDs, ways to reduce risk of HIV, referrals, risk groups, etc.?
- Are outreach workers targeting the locations where IDUs are likely to be found?

F. Community Indicators

It is also important that an HIV/STD program measure community exposure and awareness of HIV/STD prevention messages. While it is very difficult to measure behavior change related to HIV/STD prevention efforts without formal, costly KABB studies, some community indicators can suggest whether behavior change is likely, or even if it is occurring. The following are examples:

- If your organization puts out flyers or PSAs telling people to call for information about HIV/STDs, have the staff person who answers the telephone tally the number of calls received daily and weekly for the duration of the campaign and ask where people got the telephone number. This will provide feedback on the strength and visibility of your message. It will also provide some indication as to the extent of community need for HIV/STD information.

- If a community outreach effort or media campaign urges people to get tested, HIV testing sites can keep track of the number of people requesting tests before and after the campaign. Information about how people learned about the testing center should also be sought to find out what types of outreach efforts are effective.

- Use your agency's AIDS/STD hotline to develop an understanding of the types of information needed in your community. Periodically, conduct an analysis of why people call your AIDS/STD hotline (e.g., to find out symptoms of HIV and other STDs, obtain HIV/STD testing information, ask HIV/STD transmission questions, etc.). Document and use this background information when implementing new HIV/STD projects and when developing/revising HIV/STD-related materials.

THREE WAYS TO ASSESS COMMUNITY AWARENESS OF HIV/STDs

1. Tally the number and type of information requests made to your AIDS/STD hotline or agency on a monthly basis.

2. Track the number of HIV/STD tests administered monthly at a local testing site.

3. Collaborate with local drug stores and supermarkets to track condom sales on a quarterly basis.

- Some organizations have strong visibility in the community, particularly small businesses such as local drug stores, supermarkets, and restaurants operating in a particular neighborhood. Collaborate with community business owners and orient supermarket and drug store owners to the importance and need for community HIV/STD education efforts. Then periodically ask them to keep track of condom sales, emphasizing your organization's interest in preventing the spread of AIDS and other STDs in the community by getting more people to adopt condom use.

Community indicators can also provide a longer-term indication of the overall impact of HIV/STD education and prevention efforts. Suppose your organization is about to begin a major project in a defined community or neighborhood. *Have baseline data available before the project starts* concerning number of calls requesting HIV/STD information, number of people requesting HIV tests, number of requests for flyers/brochures, etc., per week or month. Continue to collect and report the data after the project begins. Graphing changes in requests for information, products, and services over time suggests whether prevention efforts are having an effect. Also, have community health centers or other social service agencies you collaborate with ask a sample of their callers/clients about how they learned about the service. This will give you more information about the effects of your project's specific interventions.

Aggregating these types of data will provide a valuable indication, but not a clear measure, of the effects of your prevention efforts. Because these are community measures, and people are exposed to many different messages from a variety of sources, it is not possible to determine a cause-and-effect relationship between project interventions and observed changes in community awareness or actions.

G. Administrative Recordkeeping

Since the basis for all evaluation is information, a consistently used recordkeeping system is an essential component of any evaluation system. Basic recordkeeping forms should be maintained for all HIV/STD projects. Most ongoing publicly funded HIV/STD prevention programs have a required set of forms which must be completed regularly, tabulated monthly or quarterly, and sent to the funder in aggregated form. When there is more than one funding source for a project, each source may require the completion of different forms. At present, no standardized reporting system exists for HIV/STD education and prevention programs, and it may be difficult to develop a single set of forms for the variety of ongoing interventions.

Developing new or revising existing forms for your programs and activities requires considerable planning and some information gathering. The forms that you develop or modify will most likely be around for some time so it is important that the time invested in

this process is spent wisely. Remember that the information generated by forms is used to produce many layers of information. If your forms are poorly designed initially, you will need to repeat the same efforts in the future when you could be proceeding into the next phase of the project. The box below contains some questions you should consider as you design forms:

QUESTIONS TO CONSIDER WHEN DESIGNING FORMS

- What types of program information are mandatory -- required by funders, state or local health departments, federal agencies?
- Who or what agencies will be receiving the information?
- What other program-specific data need to be collected for internal use, and why are these data important?
- How often must you collect the information (e.g., weekly, monthly, quarterly, annually)?
- Can one standard form be developed for sources requesting similar information?
- Who will complete the forms? Will it be clients, or intake or other staff?
- Who will tabulate the information or log it into a data base?
- Who will design the form? Will you pilot test your form?

Since it is important to track the different types of interventions conducted by an organization, it may be necessary to have separate forms for each type of intervention. In any health-related education and prevention program, two types of information must be recorded:

- **Client/participant data.** These include the number and characteristics of participants in various interventions — e.g., number of youth, women, IDUs, health providers, community leaders, or other target group members reached through the project, and their most relevant characteristics, including gender, age, and ethnicity/nationality.

- **Program/intervention-based data.** These include the number and types of interventions carried out by the project, such as street outreach activities, formal education sessions, informal presentations, PSAs prepared and disseminated and number of times used or audience size reached, materials developed and number of copies disseminated. These records should also show which staff carried out each intervention and the date of each intervention.

Client/participant information is usually collected by having clients or participants complete some type of self-identification form such as a client registration/intake form. These forms are filled out one time only, and are used for maintaining basic information about clients/participants on file. Depending on how much information you need, forms can be short and brief or comprehensive, asking for name, address, demographic information, place of employment, occupation, referral source, health status information, and in some cases billing information. When the project is multi-service and serves many clients, it is important to continue collecting information after initial client contact to document the types of services the client receives. Some organizations use client encounter forms for documenting such information. Client encounter forms should be filled out each time the client receives a service, to facilitate monthly or quarterly tallying of services. These forms should ask about the type of service provided, where the service was provided, and how it was provided (See **Worksheet D**).

Forms for gathering program-related information should be tailored to the type of activity being conducted. For example, forms for street outreach sessions will need to be different from HIV/STD presentation forms. For presentations, it is important to maintain information about the site, type, and length of the presentation, as well as any restrictions the site contact person might require presenters to adhere to (See **Worksheet E**). Street outreach forms, however, should be brief, since outreach workers will have to complete these in public places. Only the most pertinent information should be sought, e.g., information about high-risk behaviors, whether clients have been tested for HIV/STDs, and the types of referrals made (See **Worksheet F**).

Client and program information forms are the basis of your program's monthly, quarterly, and annual reports. The more clear and comprehensive the forms, the easier it will be to analyze and aggregate the information needed for periodic reports. Except for a few narrative analyses of the data, the monthly or quarterly report forms should be primarily fill-in-the-blank types. Staff should only have to fill in numbers and dates. All staff should be trained to use the forms, and their completion and submission should be an absolute requirement.

TO DEVELOP USEFUL RECORDKEEPING FORMS

- Identify the major activities and interventions included in the project design.
- Review process objectives (e.g., number of each type of intervention to be carried out and number and characteristics of people to be reached), and be sure forms ask for this information.
- When interventions are very different, develop separate forms for each type of intervention or activity.
- Be sure all forms are primarily the fill-in-the-blank types.
- Have all staff review draft forms before finalizing them.
- Have staff pilot test the use of the forms, then review what worked and what didn't and make needed revisions.
- Tabulate the information monthly, and compare results with the kinds of information needed to assess progress towards process objectives and goals. Further revisions may be necessary based on this review.
- Whenever you add or change an intervention, be sure to revise the forms as needed.

H. Narrative Case Studies

Community-based organizations must develop the habit of maintaining written narrative records of program implementation, progress, and problems. Since most HIV/STD education and prevention projects have been funded as demonstration efforts, documentation of the project is essential for two reasons: (1) to enable funders to understand the full process involved in launching the project, including unexpected problems and obstacles, and (2) to enable replication of the project in other locations.

Narrative case studies are the equivalent of writing project diaries. When done systematically, case studies should provide descriptive information about a project, beginning with the planning and covering implementation and ongoing operations.

Where possible, it is worth budgeting and allocating some funds to conduct an effective case study. One staff person should be given primary responsibility for this task. Ideally, this person should be relatively detached from the actual intervention aspects of the project, and should not be a staff member whose primary goal is to make sure the project succeeds. If funding for a special "recorder" is not available, a key staff member can take on this duty. The person should be at liberty to document the negative as well as the positive experiences of the project. If an outsider, the "case study keeper" will need to meet frequently with key staff on an individual and group basis to be kept informed about the activities that are taking place. This person should also prepare a list of specific, open-ended questions in advance of the meetings. These questions might include:

- What major tasks were involved in implementing this project?
- What types of staff were needed to carry out activities of the project?
- What types of interventions were used (e.g., street outreach, in-house presentations, threatrical presentations, peer education, etc.)?
- Who were the target groups of the interventions?
- What methods were used to reach desired target groups? Were some methods more effective than others? Which one(s) and why?
- What kinds of problems/obstacles were encountered in doing outreach to target groups?
- If more than one intervention was used, which showed the most benefit and why?
- What major problems/obstacles were encountered in carrying out interventions?
- What were the reactions of the target groups to the interventions? What aspects did they seem to enjoy the most/least?
- What major programmatic problems were encountered?
- How were these problems resolved or minimized? Describe the resolution process: Who was involved from within the project? Outside of the project?
- Did external factors (factors outside the organization) contribute to the problem (e.g., unexpected budget cuts, emergencies, etc.)?

- What major hurdles/challenges were overcome?

- What advice/recommendations would you give to another community-based organization about to launch a project similar to the one at your agency?

I. Planned Variation

Uncertainty often exists about the efficacy of various intervention approaches in new or ongoing projects. The only way to learn which of two interventions is most appropriate is to test two or more approaches. Community-based organizations can run side-by-side interventions for a period of time to determine which intervention shows the most benefit with a particular target group. This strategy, referred to as **planned variation**, involves random assignment of one group of clients having similar characteristics (e.g., similar age, racial/ethnic background, educational level, etc.) to one type of intervention and another group, having similar characteristics as the former group, to a different intervention for a specific period of time. Since it can be difficult to carry out two separate interventions with two groups at the same time, you can also test the new approach by using it in place of the standard approach for a short period of time (e.g., three weeks) and then continue using the standard approach. Planned variation can be conducted several ways:

Alternative approaches: Two different approaches for conducting HIV/STD prevention sessions can be tried with similar target groups. For example, Approach A and Approach B can be tried on two groups of women, all approximately the same age and with similar racial/ethnic backgrounds to see which approach, A or B, results in increased learning. One way to assess which educational approach works better is to administer pre- and post-tests to participants in both groups. These tests should be administered to each group separately, and results analyzed independent of one another to find out what progress participants of each group made. Answers to post-tests from one group should then be compared with those of the other group to identify which approach showed the most benefit. Staff should carefully review and discuss the results, and should try the favorable approach once more before making any program changes. The results of these trials indicate the approach that may work best on *this* group of women and are not conclusive for the general population.

Augmenting services: A standard approach can be tested alongside an augmented version to see whether the augmented approach seems to increase learning or other positive measures. For example, augmenting a standard counseling session could involve spending an additional 15 minutes on a particular topic. Or, when an AIDS educator discusses risk behaviors for AIDS, the educator can spend some extra time discussing the most common STDs, and their role in facilitating HIV infection. At the end of a trial period, two focus groups could be organized for an in-depth discussion about each approach. One focus group would consist of several participants exposed to one approach, the other focus group would

consist of participants exposed to the other approach. Once focus groups have been conducted and notes written up, project staff should meet to discuss the results of each focus group and tentatively conclude which approach worked best.

Adding new elements: Add new elements to an intervention and compare against the standard intervention using two groups. Having two separate comparison groups can ensure that at the end of the trial period, participants can provide focused feedback on the strengths and weaknesses of that *one* intervention. These two comparison groups can be run concurrently or at different times depending on resource and staff availability. For example, a new element to a home-based AIDS education session for women could include a 20-minute rap session to help women get acquainted and feel comfortable before the session begins; the standard approach would have the facilitator do a brief introduction of the purpose for the session, have everyone else do introductions, and proceed directly into the session; alternatively, a new element for the session might include a role play or a game. In order for planned variation to be effective, staff must ensure that participants remain in the assigned intervention for the duration of the planned variation trial. After using the *new* approach for a specified period of time, continue using the standard approach, keeping good documentation of the sessions during the specified trial period. At the end of each session, obtain feedback from the women using a post-session assessment form, informal survey, or oral interview. After the home-based sessions have been tested, compare feedback from that session with feedback from the standard sessions to see which one women liked best and learned from the most.

V. SELECTING THE APPROPRIATE EVALUATION METHODS FOR HIV/STD INTERVENTIONS

The purpose of this section is to demonstrate how the various evaluation techniques discussed earlier can be combined and applied to certain HIV/STD education and prevention activities. While the approaches for carrying out HIV/STD activities vary across agencies, all programs have similar basic "ingredients" which should be assessed regularly in order for programs to be successful.

When developing an evaluation plan for your project, plan to use not just one, but several evaluation techniques. Combining various techniques or "building blocks" to obtain information about a project can provide a more in-depth understanding of how a program or an activity is working. For example, using focus groups and informal surveys to assess how well a high-school-based AIDS education program is going can yield more information about the activity than only using informal surveys. The information generated from using more than one assessment technique will also improve the reliability of the evaluation.

Three types of HIV/STD prevention and education activities are used as examples below: media and community outreach campaigns, informal or street outreach interventions, and HIV counseling and testing programs. Under each type of activity, aspects of the activity which should be evaluated are identified, followed by suggested evaluation techniques.

A. Media and Community HIV/AIDS Outreach Campaigns

Media and community outreach campaigns are often used to reach large audiences with education and prevention messages about health and HIV/STD-related issues. The messages are often designed to reach specific population groups such as teenagers, farmworkers, drug users, limited-English-proficient adults, or women. Media campaigns can include public service announcements (PSAs) on television or radio, newspaper advertisements, press conferences (often used to announce a campaign), and special programs such as talk shows. Community outreach campaigns, which may occur alone or in coordination with media campaigns, often use buttons, tee-shirts, flyers, posters, and resource kits to convey messages to a target group. These campaigns tend to reach smaller numbers of people than media campaigns.

KEY AREAS FOR EVALUATION:

Some important areas of a media and/or community outreach campaign which should be evaluated include:

- **What is the message, and how will it be delivered?** Make sure the concept or message to be transmitted is correct and to the point. Explore the options for conveying the message and select the most appropriate media or outreach approach — e.g., a message encouraging IDUs to come for HIV/STD testing at an anonymous testing site, conveyed through Spanish-language radio PSAs.

- **Materials for distribution.** All visual or written intervention materials — such as press releases, videos, buttons, posters, resource kits, bumper stickers, and flyers should undergo review for consistency of message, technical accuracy, clarity, and cultural appropriateness.

- **Whether the desired target group is being reached.** Assessing the extent to which the campaign actually reaches the intended number of targeted individuals is important; for example, if a television PSA on STDs is supposed to reach at least 100,000 Hispanic youth, verify that this really happened by checking Nielsen* and/or STAR** reports which indicate the number of households reached and the audience size for the PSA.

- **Effects of the campaign.** Both positive and negative effects of the campaign on the target groups should be documented and assessed. For example, if you want to assess whether people exposed to a radio PSA urging HIV-testing for individuals practicing high-risk behaviors actually got tested, contact the testing site(s) referred to in the PSA and have them ask persons how they found out about the testing site(s).

Evaluating Project Design:

If you are in the planning stages of a media or community outreach campaign, the following evaluation techniques can be useful for obtaining feedback:

- **Expert reviews.** Media, graphics, public relations, health, AIDS, and STD experts; staff of local and national Hispanic organizations; and community volunteers can be sought to review the proposed content of messages, layout,

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* Nielsen Media Research conducts national/local TV and cable research services. For more information, write to: Nielsen Media Research, 1290 Avenue of the Americas, New York, New York, 10104, or call (212) 708-7500.

** Strategy Research Corporation provides national/local radio and TV Hispanic audience rating services, conducts Hispanic market studies, station profile and other studies. For more information, write to: Strategy Research Corp., 100 NW 37th Avenue, Miami, Florida, 33125, or call (305) 649-5400.

format, accuracy, language and cultural appropriateness; experts can also suggest other names and organizations to contact for additional assistance.

- **Focus groups.** Well-organized focus groups can reveal reactions of target group members to proposed messages, provide a better understanding of the information needs of the target group, and suggest feedback on specific language, approaches, and materials.

- **Community interviews.** These interviews can provide general feedback on the proposed content and appropriateness of written/visual materials and strategies for the campaign. Staff can use "captive" audiences to collect this information from groups of high school students, clients of drug and alcohol treatment centers, and clients of community-based organizations.

Evaluating Project Implementation and Outcomes:

When a media or community outreach project has been ongoing for some time and you want to assess its implementation and outcome, you can use some of the following evaluation techniques:

- **Documentation.** Track all the materials disseminated during the campaign, including quantity of flyers, posters, PSA tapes, and other materials; maintain an updated list of all the places materials have been sent; record the names of radio and TV stations which have received PSA tapes and track which stations have agreed to broadcast the tapes.

- **Broadcast and print media reporting of use of PSA.** Ask station managers to record and report the number of uses of a PSA. Arbitron reports* will indicate the number of households who were tuned in to the radio at specific times, and Nielsen data will do the same for television. These reports also indicate the size of the audience for the PSA. For example, they can indicate that 100,000 homes were tuned in and saw a PSA on television. You can also ask magazines and newspapers carrying your advertisements for the date of the issue, the page number of your ad, as well as the circulation of the newspaper or magazine; many magazines also have subscriber profiles.

- **Community measures.** If the campaign asks people to call an AIDS or STD hotline for more information, arrange to tally the number of telephone calls

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* The Arbitron Company provides television and cable ratings, commercial monitoring reports, and product sales tracking information. For more information, write to: The Arbitron Company, 142 W. 57th Street, New York, New York, 10019, or call (212) 887-1300.

- **Community measures.** If the campaign asks people to call an AIDS or STD hotline for more information, arrange to tally the number of telephone calls made to the hotline several weeks before, during, and after the campaign; operators should ask callers where they heard about the hotline. Similar documentation can be done by HIV/STD testing sites where a campaign urges people to get tested. In places where certain stores are a major source of condoms, condom sales at local pharmacies can be tracked. Analyzing such information will give some indication about whether the campaign had any effects on the community.

- **Key-person interviews.** Inform local agencies about your HIV/STD campaign efforts. Ask agencies who work directly with your campaign's target groups to ask their clients whether they know about the campaign, how they heard about it, their opinions, and what they liked and disliked about the campaign. Then schedule a time to interview the agency staff.

- **Informal surveys.** At the end of a campaign, visit local agencies (with prior consent of local agency staff) where you are likely to find individuals representing the target group of your campaign and interview clients informally, either orally or using short surveys. You can survey a specified number of individuals at each of these settings — perhaps every third person who enters for services on a given day. Ask clients if they heard about or saw the campaign, and if so, what new information was learned and what, if any, actions were taken as a result of hearing campaign messages.

B. Informal or Street Outreach Interventions

Street outreach is perhaps the most challenging of all HIV/AIDS education and prevention activities to evaluate. The targeted groups are hard-to-reach; they tend not to go to "typical" settings for help such as hospitals, clinics, and drug treatment centers, making traditional methods of education ineffective. Yet, these groups are most in need of HIV/STD education and prevention efforts because of high-risk behaviors such as injecting and other drug use and prostitution. There is little control over the settings in which street outreach takes place, and conducting follow-up can at best be "hit or miss" — contacts may not stay in the settings where they were first found. Street outreach is usually an informal, one-time contact activity that relies more on one-to-one personal interaction than on written materials. The outreach approach, length of time, and content of messages may vary widely from one outreach worker to another. Regardless of these variations, almost every street outreach intervention has certain common features which can and should be evaluated.

Key Areas for Evaluation:

Some important areas of informal or street outreach interventions which should be evaluated include:

- **Whether the desired target group is being reached.** Street outreach *should* be targeting individuals whose behavior places them at high risk of HIV/STD infection. Make sure to assess how well your outreach strategies are reaching these groups.

- **Content of information.** The time spent with each street contact is often insufficient for outreach workers to provide all the important information about HIV/STDs. Outreach workers must therefore communicate *accurately* the key points about HIV/STDs, such as the specific behaviors which can lead to HIV/STD infection, methods for reducing HIV/STD risk, HIV and STD diagnostic and testing information, and referrals for alcohol and/or drug treatment.

- **Delivery of messages.** It's important to assess whether outreach workers are delivering HIV/STD messages in a clear, comprehensive, sensitive, culturally appropriate, and comfortable manner.

- **Effects of messages on individual behaviors.** While this is by far the most difficult aspect of street outreach to evaluate, it is very important to try to find out how individuals who were reached responded — whether they are getting tested, seeking counseling, enrolling in alcohol and/or drug treatment programs, and/or asking for more information about HIV/STDs.

Evaluating Project Design:

If you are planning an informal or street outreach intervention, use the following techniques to obtain feedback on your program plans, and to enable you to make any changes before its full implementation:

- **Informal surveys.** Surveying individuals from the community who are representative of your target group can offer valuable advice about the best locations for reaching people like themselves; they can suggest the major points that need to be communicated as well as effective methods or styles for establishing rapport with individuals. Usually, you will want to use a brief survey form or even a tape recorder for these interviews. Tabulate responses to close-ended questions, and list hints and special concerns.

- **Key-person interviews.** Consider interviewing heads of local social service agencies, drug abuse counselors, community volunteers, and neighborhood activists for information and insight on cultural issues to be considered in doing outreach, unique problems and needs of the target groups, tips on how best to approach certain target groups, and where to find various target groups. A semi-structured interview guide and a tape recorder are useful for such interviews.

- **Documentation.** The design of forms for documenting street outreach contacts is important. Forms should be brief to enable workers to complete them quickly. Yet, they should generate important information about street contacts. Forms should ask for the number of street contacts made, types of high-risk behaviors, characteristics such as gender and approximate age, and location. Internal information systems should also be in place before the program begins. Assign each staff person responsibility for completing certain tasks such as collecting street outreach forms, documenting aggregate data on a monthly or quarterly basis, producing summary reports, and disseminating the information. Equally important, carry out early reviews and obtain street worker feedback to be sure that forms are being used.

Evaluating Project Implementation and Outcome:

When an informal or street outreach intervention has been ongoing for some time, assess its implementation and outcome using some of the following techniques:

- **Community indicators.** If you refer people for counseling, testing, or HIV/STD information, see if they followed your advice. Assess the extent to which the sites are experiencing a rise in clients. Sites may include community social service agencies, pharmacies, health centers, STD clinics, and HIV testing sites. If you have referred individuals to an AIDS hotline telephone number, find out if increases in the number of calls have occurred since your project began. Always try to get referral sites to ask new clients and contacts who told them to come, or how they found out about the site.

- **Documentation.** Maintain daily records of street outreach activities, and tabulate on a weekly or monthly basis. When noticeable increases or decreases occur in the number of contacts made, record the reasons for these changes, if known. Also, leave some space at the end of street contact forms for outreach workers to record comments made by contacts. After rapport has been established with some street contacts, these individuals may willingly offer valuable information about the steps they have taken to reduce high-risk behaviors such as seeking counseling, visiting an STD clinic, obtaining

condoms and/or bleach kits, or about their efforts to share AIDS information with their sex or drug-using partners.

- **Role plays.** Regular assessment of staff, particularly those working directly with target groups, is also important for ensuring a successful program. Make sure they understand the information and messages to be communicated to clients on the streets; ask if they have encountered any problems or have questions concerning their work. Periodically, outreach workers can perform role plays of street outreach sessions where one person plays a client and another plays the outreach worker. Outside observers and experts should be present to provide feedback on delivery style, content, and accuracy of messages.

- **Informal surveys.** It is usually impossible for staff to follow up on every street outreach contact. Contacts are often anonymous, and many persons reached may have no fixed address, even if staff had the time to look for them at home. When it is possible to locate individuals who have previously received information and who feel comfortable with staff, have staff ask them whether the outreach effort was useful, whether they learned new information, and whether they took some recommended action — sought counseling or have begun using bleach and water to disinfect used needles.

- **Key-person interviews.** Ask staff of local drug treatment centers and counseling sites to find out how new clients found out about the site — whether they heard about it through street outreach, and if so, what are the general reactions to and opinions about the information being delivered on the street.

C. HIV Counseling and Testing Programs

CDC has supported the widespread implementation of HIV counseling and testing programs as a crucial prevention activity to reduce the spread of HIV disease. HIV counseling and testing programs are based on the assumption that most individuals will change high-risk behaviors if they are aware of their serostatus and receive appropriate counseling.[9] Counseling and testing services usually include confidential or anonymous HIV testing, pre- and post-test counseling, and, if an individual tests positive for HIV, partner notification and referral.

HIV counseling and testing serve two main functions: (1) they are a source of primary prevention by educating uninfected persons about assessing and reducing their risks, and (2) they serve as a source of secondary prevention by counseling infected persons about

maintaining their health and preventing transmission and by providing referral to other services.

Publicly-funded counseling and testing programs offer two options for HIV testing: confidential or anonymous testing. A person requesting confidential testing consents to having his/her test result become part of his/her medical record. There are several arguments for confidential testing. First, confidential testing enables testing sites to contact and inform individuals who test positive for HIV but do not return for test results. Second, doctors theoretically are better able to prescribe treatments for HIV and other illnesses if they are fully informed about a patient's health. Third, partners of HIV-infected individuals can be notified, can ask questions, and can obtain information and referrals to other services. Additionally, HIV-infected persons can take advantage of early intervention services by beginning drug therapy or becoming involved in clinical trial programs. When persons choose anonymous testing, individuals are assigned numbers only. Names are not obtained, and test results cannot be included in the medical record. Anonymous testing makes it impossible for a testing site to contact and inform a person who tests positive for HIV and does not return for test results. However, it also provides absolute protection of confidentiality, which may cause more people to obtain testing.

Key Areas for Evaluation:

When evaluating HIV counseling and testing programs, assess the areas which contribute most to an effective service delivery system. These may include the following:

- **Adequacy of the counseling and testing procedures** — reflecting the extent to which the procedures meet client needs, which include confidentiality, reasonable waiting periods, and secure linkages between counseling and testing. That is, HIV counseling must always precede testing, and in the case of positive test results, must follow HIV testing. The pre-test counseling session must clearly describe the testing process and procedures for obtaining test results. The time delay between testing and availability of test results and post-test counseling should be as short as possible to ensure the retention of individuals throughout the entire testing procedure; the provision of test results should be confidential and free of barriers; and state/local policies on partner notification should be carefully reviewed and followed.

- **Adequacy of the counseling actually provided** — clients often need support, reassurance, sensitivity, and understanding from counselors; a *risk assessment* is also important, where the counselor tries to elicit key information about the client's risk behaviors to obtain an understanding of why and how the client is at risk of HIV/STDs and make appropriate referrals; clients should also receive *accurate and appropriate information* about transmission of the virus, risk reduction behaviors, and *meaning of test results*. For clients who test

HIV-positive, needs such as *coping skills* — how to accept and live with HIV/AIDS — information and counseling about medical care, mental health services, partner notification, treatment options, and clinical trials information are especially important.

- **Proportion of clients that complete all counseling and testing procedures** — this includes returning for test results, and for individuals testing HIV-positive, obtaining post-test counseling.

- **Accessibility of services** — determined by analyzing barriers to services such as remote location, inconvenient hours of service, lack of bilingual health care providers to serve limited-English-proficient clients, and the likelihood of being seen by friends or family.

Evaluating Project Design:

A variety of evaluation techniques can be used to evaluate current HIV counseling and testing methods, systems, and written materials. These include the following:

- **Key-person interviews.** Contact other already-established testing sites and interview their key staff to obtain advice and suggestions on designing and implementing an HIV counseling and testing program, or ask for feedback on your ideas and plans for designing the program; find out what obstacles were incurred in the early planning and design stages and how they were resolved; also ask for recommendations on other places and people to contact.

- **Expert reviews.** Have experts from STD clinics, community health centers, and other testing sites review your proposed plan and make suggestions for improvement.

- **Demonstration sessions.** Schedule a day or two for conducting demonstration sessions to assess what is and is not working well in your program. During demonstration sessions, also ask clients directly or through surveys about their opinions and what improvements they recommend.

Evaluating Project Implementation and Outcomes:

- **Documentation.** This includes ongoing collection, analysis, and documentation of the monthly client caseload, number of HIV tests provided on a weekly and/or monthly basis, number of new clients per month, the percent of client returns for test results, and percent of clients tested who received post-test counseling, number of partner contacts, and referral

information. A detailed review of these data can reveal problems which need to be explored further.

- **Informal Surveys.** Administer short one-page informal surveys after clients have received pre-test counseling, while they are waiting to be tested, to obtain their thoughts, opinions, and feedback concerning the counseling session (e.g., whether the session revealed new information, whether it was clear and comprehensive, whether there were aspects they didn't like, and whether the session led them to want to change high-risk behaviors). Staff should collect surveys from clients either before or after they receive their tests. Surveys could also be handed out when clients come in to pick up their test results. (This would, of course, only be appropriate for clients who test HIV-negative.) The information collected from surveys can suggest why clients may not complete all counseling and testing procedures (e.g., test results take too long) and suggest ways to improve the process.

- **Non-participant observers.** Having non-participant observers during pre-test counseling sessions can be a useful evaluation technique since pre-test counseling sessions are generally conducted in groups. Observers can take notes of reactions and frequently-asked questions from the group, and consider some of the following questions during their assessment:

  - What is the message being given? To what degree is testing, risk reduction, or both being encouraged?

  - What is the nature and quality of the counselor/presenter and group interaction? Does the counselor demonstrate good presentation skills?

  - How are counseling messages modified for different clients/risk groups?

  - Are counseling messages culturally sensitive?

  It is very useful for the non-participant observer to have a list of important points the counselor is expected to cover during the session. As the counselor covers each point or asks important questions, the observer should check these items off the list. The observer should also record important questions asked or comments made by the clients that are not addressed by the counselor during a standard counseling session. At the end of the session, key staff should review the results of the session. Two or three similar sessions should generally be observed before reaching conclusions and providing feedback to the counselor and his/her supervisor.

- **Key-person interviews.** Interview heads of support group agencies for HIV-positive persons, gay organizations, drug treatment centers, counseling centers, etc., — places where testing sites would most likely refer HIV-positive individuals — in order to get an idea of the number of persons referred to these various organizations by testing sites. This will provide some indication about the kind of information being communicated to HIV-positive persons during post-test counseling sessions.

- **Planned variation.** If you are genuinely uncertain about which of several counseling approaches is more appropriate, implement a planned variation for a two-month period by testing a modified procedure against the standard procedure to find out which works better. For example, the modified procedure might be to provide clients of testing sites new information during the pre-test counseling session. This modified approach could be tested for one month and the standard approach should also be tested for one month. Careful documentation of the number of participants attending pre-test counseling sessions and number of clients returning for test results the week after (HIV test results are usually available one week after testing) will be especially crucial during the two months in order to assure an accurate comparison of the results of both approaches. At the end of the two-month trial period, compare the number of client returns for test results with the number of clients attending pre-test counseling sessions the week before for each trial month. The approach showing the most client returns may be the most favorable approach to use regularly. However, before making any major changes to your program, test the approach more than once.

VI. CONCLUSION

Hispanic community-based HIV/STD programs cannot delay the implementation and systematic use of program evaluation techniques. Community-based organizations must take the lead in compiling information and disseminating their achievements to government officials, funders, and other local community groups. This will provide Congress, policy makers, and the general public a greater understanding of the significance of and need for community-based HIV/STD programs.

More information and guidance on practical methods for evaluating HIV/STD education and risk reduction activities are badly needed in the Hispanic community. Much of the existing information is inappropriate for the kinds of HIV/STD-related activities conducted by Hispanic community-based organizations and for the populations they serve. Evaluation methods are often complex, even overwhelming, and tend to concentrate heavily on costly and highly structured quantitative research rather than on field-based, lower-cost, qualitative program evaluation. Needed are basic "hands-on" or "cookbook-style" evaluation manuals that can help remove much of the mystery associated with evaluation. This guide is intended to help meet this need.

A major priority for the NCLR AIDS Center is to collaborate closely with Hispanic community-based organizations to strengthen their capacity to evaluate their HIV/STD programs. This is achieved through the continuing development of culturally appropriate guides and manuals, on-site technical assistance, and formal evaluation training for community groups. This is the second in a series of evaluation manuals designed for use by Hispanic community-based organizations. A third manual on evaluation is planned.

Hispanic community-based organizations can offer valuable assistance in the development of more appropriate information on evaluation. By testing the program evaluation techniques described in this manual, community-based organizations can help to identify strengths and weaknesses of these techniques as presented and suggest modifications and improvements. Organizations may recommend alternative techniques for evaluating health education and risk reduction activities not discussed in this manual, which can also benefit other community-based programs. This information can only be obtained by testing various evaluation techniques, documenting, and sharing or disseminating their results.

Finally, we must not lose sight of the basic mission behind all HIV/STD-related activities — to save as many lives as possible and to prevent the spread of HIV/STDs. In the absence of an effective cure for HIV/AIDS, it is critical to identify primary prevention programs or approaches that show benefits in motivating individuals to abstain from, or reduce levels of, high-risk behaviors, and that encourage individuals to adopt the consistent use of practices which reduce the likelihood of HIV/STD infection.

This manual describes many techniques that can be used to evaluate the effectiveness of these programs. By simply taking the time to consider which techniques are most suitable for a given intervention, and then coordinating the key pieces (e.g., staff, target group, materials, etc.) all community-based organizations should be able to effectively develop and implement an evaluation plan for their HIV/STD prevention programs.

ENDNOTES

1. *A Decade of Denial: Teens and AIDS in America.* A Report of the Select Committee on Children, Youth, and Families. Washington, D.C.: U.S. House of Representatives, 1992.

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APPENDIX
WORKSHEETS

Worksheet A: Goals and Objectives. The purpose of this form is to record key project information such as project goals, outcome and process objectives, and project deadlines. Other information to record on this form is a description of the project, its start and end date, and the name of the project director. This form should be updated to reflect any revisions made to the project (e.g., change of project director, revised outcome or process objectives, changes in deadlines, etc.).

Worksheet B: Community Interview Guide. This guide is useful to document important information about a community interview session. Section I of the form asks for a description of the session -- the date, time, site, number and description of participants, and key staff members involved in the session. Section II lists sample questions which the facilitator can ask the group.

Worksheet C: HIV/STD Education Workshop Post-Session Assessment Form. Post-session assessment forms provide trainers and facilitators of workshops and training seminars written records of the participants' overall assessment of the training session. This form is handed out to participants once the workshop or training seminar has ended.

Worksheet D: Client Encounter Form. This form documents each time a client receives HIV/AIDS-related services from an agency. It records such information as the type of services provided, date and site of staff-client encounter, staff persons providing services, and results of the encounter. This form can be completed by staff immediately following the client encounter.

Worksheet E: HIV/STD Presentation and Workshop Logging Form. The purpose of this form is to track the types of presentations or workshops conducted by staff of HIV/STD programs. The form asks for such information as site of training, characteristics of participants, and level of group involvement. The sections on *General* and *Site Information* can be completed by staff before the date of the presentation or workshop (whenever this information is available). The remaining information can be completed immediately following the session.

Worksheet F: Street Outreach Contact Sheet. This is an adaptation of a form ("street card") used by Guadalupe Center, Inc. of Kansas City, Missouri. The street card, completed by outreach workers, documents key information about each street contact, including time and location of street contact, demographic information, type(s) of risk behaviors for HIV/STDs, HIV counseling and testing information, and type of referral(s) made by the outreach worker.

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WORKSHEET A:
GOALS AND OBJECTIVES

Project Name: _____

_____

_____

Project Start Date: _____

Project End Date: _____

Project Director: _____

_____

_____

Description *(briefly describe the target groups and intervention methods of the project)*:

_____

_____

_____

_____

_____

_____

_____

I. Goals

List the major goal(s) of the project.

Goal 1: _____

_____

_____

_____

_____

Goal 2: _____

_____

_____

_____

_____

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II. Objectives

a. List the outcome objective(s) of the project AND expected date(s) of completion.

(This states what will be different as a result of the project.)

Example: To increase the knowledge of at least 50 clients attending Elwood STD clinic about the major transmission modes and methods for reducing the risk for HIV infection within six months after project initiation.

1. _____

2. _____

3. _____

b. List all major process objectives (or activities) AND dates of completion for each.

Example: To develop an HIV/STD education and prevention training curriculum, including agenda, exercises, and reference materials within one month after project initiation.

Example: To conduct three HIV/STD education and prevention workshops targeting a total of 45 clients from the Elwood STD Clinic within three months after project initiation.

1. _____

2. _____

3. _____

4. _____

5. _____

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WORKSHEET B:
COMMUNITY INTERVIEW GUIDE

I. General Information

a. Provide a brief description of the activity. _____

_____

_____

_____

b. Date of activity: _____

c. Time: _____

d. Activity Site: _____

Address: _____

e. Provide a description of the participants. If you are targeting specific groups, please specify the group(s) and the number of individuals in each group (e.g., number of teenagers, number of Hispanic women, number of recovering addicts, etc.):

_____

_____

_____

_____

f. Total number of participants (excluding project staff): _____

g. Briefly describe the methods used for recruiting the participants: _____

_____

_____

_____

_____

h. Language(s) used in the session: _____

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i. Provide the names of all project staff involved in this activity:

Community interview coordinator(s): _____

_____

Facilitator(s)/moderator(s): _____

_____

Recorder(s)/observer(s): _____

_____

II. Interview Questions

(The following are sample questions based on the case study shown on page 31. The facilitator can ask the group these questions once the session has ended. The observer should write down as many of the responses to the questions as possible.)

1. What is this skit all about?
2. What kind of words would you use to describe the skit?
3. Which character roles did you like best/least?
4. What were the most powerful [emotionally stirring] scenes during the skit?
5. Did the skit portray real-life situations? Why or why not?
6. Did the skit portray real-life characters? Why or why not?
7. What message(s) did you learn from this skit?
8. How would you apply what you have learned from this skit to your daily life activities?
9. [Ask students] Would you recommend showing this skit to other high school students? Why or why not?
10. Is this skit useful for other groups besides teenagers, such as parents and teachers? Why or why not?
11. What additional character roles should have been portrayed in the skit?
12. What changes in the skit would you recommend, to make it more effective in getting its message across?

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WORKSHEET C:

HIV/STD EDUCATION WORKSHOP POST-SESSION ASSESSMENT FORM

In order to help us improve future training workshops, we would appreciate your feedback on *this* training workshop. Please complete this brief assessment form and return to a trainer before leaving the session. Thank you for your assistance.

1. How much did you know about HIV/STDs before this training workshop?

- ❑ A lot
- ❑ A fair amount
- ❑ A little
- ❑ None at all

2. How would you rate the workshop in terms of its overall value to you on a scale of one through ten, where 1 = Poor and 10 = Excellent. Please circle one number.

1	2	3	4	5
6	7	8	9	10

3. How would you rate the following aspects of the workshop:

	Excellent	Very Good	Good	Fair	Poor
a. Training site and facilities?	❑	❑	❑	❑	❑
b. Hand-outs and take-home materials?	❑	❑	❑	❑	❑
c. Organization of materials and hand-outs?	❑	❑	❑	❑	❑
d. Trainer presentations?	❑	❑	❑	❑	❑
e. Exercises and participant interaction?	❑	❑	❑	❑	❑
f. Content of the training?	❑	❑	❑	❑	❑

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4. **After completing this seminar, can you:**

	Yes	No	Unsure
a. Identify the major ways HIV/STDs is passed on to another person?	❑	❑	❑
b. Identify "high-risk" behaviors for HIV/STDs?	❑	❑	❑
c. Explain at least three ways for reducing the risk of HIV/STDs?	❑	❑	❑
d. Discuss the major differences between HIV and AIDS?	❑	❑	❑
e. Explain the "latency" period between HIV infection and full-blown AIDS?	❑	❑	❑
f. Advise a friend about the likelihood of getting HIV/AIDS through a blood transfusion?	❑	❑	❑
g. Tell friends what to do if they think they have been been infected with HIV/STDs?	❑	❑	❑
h. Explain the relationship between non-HIV sexually transmitted diseases and HIV?	❑	❑	❑

5. **Will you change any behaviors (e.g., sexual and/or drug use) that may cause you to become infected with HIV/STDs as a result of what you learned during this workshop?**

❑ Yes ❑ No ❑ Unsure

If so, how will you change behaviors?_____

_____

_____

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6. Will you try to educate friends and/or family about the ways HIV/STDs are passed on and how to reduce the chances of becoming infected?

❑ Yes ❑ No ❑ Unsure

7. What was your favorite topic or section during this training workshop?_____

_____

_____

_____

8. What was your least favorite topic or section during this workshop?_____

_____

_____

_____

9. Would you recommend this workshop to your friends and/or family?

❑ Yes ❑ No ❑ Unsure

10. Please list any other topics that should be included in this workshop.

_____

_____

_____

11. Please add any other comments._____

_____

_____

_____

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WORKSHEET D:
CLIENT ENCOUNTER FORM

*Complete this form for **each** one-on-one client encounter session. This form will be used to track HIV/STD-related services provided to clients. When completed, place form in client's file.*

1. **Date of Encounter:** _____

2. **Client Name/I.D. #:** _____

   _____

3. **Has client received services from this agency before?**

   ❑ Yes ❑ No

   If yes, what was the date of the last session? _____

4. **Where is the session taking place? Please check one:**

   ❑ Counselor's office
   ❑ Client's Home
   ❑ Church
   ❑ School
   ❑ Other (please specify): _____

   _____

5. **Who initiated the session? Please check all that apply.**

   ❑ Client
   ❑ Staff
   ❑ Family
   ❑ Spouse/Companion
   ❑ Other (please explain): _____

   _____

6. **Reason(s) for the session:** _____

   _____
   _____
   _____
   _____

7. **Were others present at the session besides the client and staff?**

   ❑ Yes ❑ No

   If yes, who else was present (e.g., spouse, family, friend)?

   _____
   _____
   _____

8. **What type(s) of services were provided to the client during this session (check all that apply)?**

   ❑ HIV/AIDS 101 and other STD education
   ❑ HIV/STD testing
   ❑ Substance abuse counseling
   ❑ Information and referral to other services **within** the agency (e.g., support groups, companion programs, etc.)

   List types of services referred to: _____

   _____
   _____

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❑ Referrals to other HIV/AIDS-related services **outside of the agency** (e.g., HIV counseling and testing, drug and alcohol treatment, etc.)

List types of services referred to: _____

_____

_____

❑ Other (please explain): _____

_____

_____

9. Has client followed up on referrals made at the last session?

❑ Yes ❑ No

If yes, what action did client take? _____

_____

_____

_____

_____

_____

10. Has client indicated that s/he has made any behavior changes to reduce the risk of HIV/STDs?

❑ Yes ❑ No

If yes, please explain: _____

_____

_____

11. Is there any other evidence that client is more knowledgeable about HIV/STDs?

Comments: _____

_____

_____

_____

_____

12. Has a follow-up session with client been scheduled?

❑ Yes ❑ No

13. Total Time of Session: Hours _____ Minutes _____

14. This form was completed by: _____

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WORKSHEET E:

HIV/STD PRESENTATION AND WORKSHOP LOGGING FORM

Staff must complete this form for every HIV/STD presentation or workshop held.

I. General Information

a. Name of Presentation/Workshop: _____

b. Date(s) of Presentation/Workshop: _____ Time: _____

c. Length of Activity: _____

d. Briefly describe the content and purpose of the activity.

_____

_____

_____

_____

_____

_____

e. Trainers/Facilitators: _____

_____

_____

f. Language of Presentation/Workshop (check one):

❑ English ❑ Spanish ❑ Both

II. Site Information

a. Name of Agency or Site Location: _____

_____

_____

b. Address: _____

_____

c. Telephone #: ( ) _____ Contact Person: _____

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d. Does the site have any restrictions (e.g., no condom distributions, no use of specific terms, etc.) which presenters must adhere to? Please explain.

_____

_____

_____

e. Describe the types of written/visual materials used during presentation/ workshop. _____

_____

_____

_____

III. Participant Information

a. Describe the primary participant or target group (e.g., all males, all females, young parents, high school teenagers, farmworkers, etc.): _____

_____

_____

_____

b. Number of Participants:

_____ Males _____ Females _____ Total

c. Primary Age Group (check one):

❑ 13-19 ❑ 20-24 ❑ 25-29

❑ 30-40 ❑ 41 and over ❑ Mixed ages ❑ Unknown

d. Race/Ethnicity (specify the number of individuals in each racial/ethnic group if known):

_____ Hispanic → Indicate the number within each Hispanic subgroup, if known:

_____ Black (non-Hispanic) _____ Mexican American _____ Central American

_____ White (non-Hispanic) _____ Puerto Rican _____ South American

_____ Other (specify) _____ Cuban _____ Other

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e. Did the group show interest in the workshop/presentation (explain)?

_____

_____

_____

f. Assess the level of group participation (e.g., did everyone participate, only a few?). _____

_____

_____

_____

g. Assess the performance of participants on the group exercises (e.g., were there problems understanding the exercises? Were they able to complete all exercises?). _____

_____

_____

h. How many participants stayed throughout the entire workshop/presentation?

_____

i. What specific area(s) did the group have problems understanding? _____

_____

_____

_____

j. What specific area(s) or topic(s) did the group seem to enjoy most? _____

_____

_____

k. Were pre- and post-test surveys administered?

❑ Yes ❑ No

l. Did participants have problems completing these? Explain. _____

_____

_____

_____

_____

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WORKSHEET F:

STREET OUTREACH CONTACT SHEET

(Adapted from Street Card used by Guadalupe Center, Inc.)

Outreach Workers: Complete this form for each street contact made, obtaining as much of the information as possible. Names and addresses of contacts are optional.

I. General Information

a. Worker Initials: _____

b. Contact #: _____

c. Date: _____

d. Time: _____

e. Location: _____

II. Contact Description

a. Name (optional) _____

b. Address (optional) _____

_____

c. Sex: ❑ Male ❑ Female

d. Approximate Age _____

e. Race/Ethnicity _____

III. Substance Use (Check all that apply)

a. ❑ Injecting drugs ❑ Alcohol ❑ Other

b. Frequency of Use: ❑ Daily ❑ Weekly ❑ Monthly

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IV. Sexual Behavior (Check all that apply)

a. Multi-partners: ❑ Yes ❑ No

b. ❑ Heterosexual ❑ Homosexual

❑ Bisexual ❑ Other _____

V. Testing/Referral

a. Tested for HIV: ❑ Yes ❑ No

b. Referred to: _____

c. Referred for (explain type of assistance needed): _____

_____

_____

_____

VI. Comments: _____

_____

_____

_____

_____

_____

_____